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# **RESTRICTIVE TRADE PRACTICES COMMISSION**

HEARINGS RELATED TO THE MANUFACTURE, DISTRIBUTION  
AND SALE OF DRUGS

## **HEARINGS**

HELD AT

**REGINA**

**EDMONTON**

**CALGARY**

**VANCOUVER**

**VICTORIA**

---

VOLUME 8-12

JULY 20, 24, 27, 31 and AUGUST 3, 1961

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Professor H.J. Fuller





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INQUIRY UNDER SECTION 42

OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:


C. RHODES SMITH, Q.C. -- Chairman

A.S. WHITELEY, M.A.          Member of the  
Commission

PIERRE CARIGNAN, Q.C.        Member of the  
Commission

F.N. MACLEOD                Combines Officer,  
representing the Director of Investigation  
and Research

Proceedings of hearings commencing at  
10 a.m., Thursday, July 20th, 1961,  
et seq in the City of Regina, in the  
Province of Saskatchewan.



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1  
2 --- On commencing at 10 a.m.

3  
4 THE CHAIRMAN: Ladies and gentlemen,  
5 as you all know, this is the opening of the hearings  
6 of the Restrictive Trade Practices Commission in  
7 Regina dealing with the inquiry which we are conduc-  
8 ting into the manufacture, distribution and sale of  
9 drugs, and at the opening this morning we would like  
10 to know who are appearing and whether they will be  
11 presenting briefs or making oral representations or  
12 if they merely are attending for the purpose of  
13 being available if questions are asked.

14  
15 Mr. MacLeod will be assisting the  
16 Commission, and we would like to know who are  
17 appearing to present briefs or to make oral repre-  
18 sentations or in any other capacity.

19 MR. PEPPER: Mr. Chairman, my name is  
20 A. Pepper. I am President of the Saskatchewan  
21 Pharmaceutical Association. When you are ready I  
22 would like to make a brief opening statement and  
23 then be available for questioning.

24 HON. MR. ERB: I am the Minister of  
25 Public Health representing the Government of  
26 Saskatchewan, Mr. Walter Erb.

27 THE CHAIRMAN: Are you making a presen-  
28 tation yourself?

29 HON. MR. ERB: On behalf of the Govern-  
30 ment.



1 THE CHAIRMAN: Are there any others  
2 who may be making representations?

3 If not, I think perhaps we might have  
4 the Government presentation now, Mr. Erb.

5 HON. MR. ERB: Thank you.

6  
7  
8 SUBMISSION OF THE GOVERNMENT OF SASKATCHEWAN

9 Appearances: Hon. Walter Erb, Minister  
10 of Public Health  
11 Wilfred Totten, Administra-  
12 tive Pharmacist, Department  
13 of Public Health  
14 Carl Wenaas  
15 Dr. J.G. Clarkson, Director  
16 of Medical Services Division

17 HON. MR. ERB: Mr. Commissioner, may  
18 I draw your attention at the beginning to the letter  
19 which is addressed to you, sir, from the Acting  
20 Premier of Saskatchewan, Mr. Lloyd, expressing his  
21 pleasure in being able to present our submission to  
22 you on this occasion. On the next page is the Table  
23 of Contents, and underneath that the appendices as  
24 they are listed in the book, and then follows the  
25 main body, and at the end of the main body will be  
26 found various statistical information which is  
27 referred to in the main body.

28 Dear Sir:

29 I am pleased to transmit to the  
30 Restrictive Trade Practices Commission a submission  
indicating briefly the views of the Government of  
Saskatchewan regarding the Commission's inquiry into





1 the cost of drugs and current trends in the drug  
2 industry.  
3

4 Our submission has been prepared  
5 jointly by the Department of Public Health and the  
6 Economic Advisory and Planning Board and I trust  
7 that it will be of some assistance in this very  
8 important investigation.

9 Signed. W.S. Lloyd, Acting Premier.

10 Introduction

11 The Government of Saskatchewan welcomes  
12 the opportunity to make this submission to the  
13 Restrictive Trade Practices Commission particularly  
14 because of our long-standing interest in programs by  
15 which the highest standards of health care might be  
16 made universally available and because of the increa-  
17 singly important role played by drug products in  
18 medical practice. With the launching of public pro-  
19 grams to supply necessary drug treatment for low-  
20 income groups in our province, and the establishment  
21 of comprehensive hospital insurance which also covers  
22 most drugs provided during in-hospital care, the cost  
23 of drugs has impinged more and more directly on the  
24 public treasury. The establishment of a medical care  
25 program will make it even more important that drug  
26 prices should be at reasonable levels and that certain  
27 undesirable trends in the drug industry, to which we  
28 shall refer, should be controlled. What is true of  
29 Saskatchewan we believe to be true of other provinces  
30



1 in this regard. Therefore this investigation into  
2 practices of the drug industry is most opportune.

3  
4 In this submission, we have not sought  
5 to analyze in detail nor at length the various  
6 aspects of the Canadian drug industry. Instead we  
7 have relied on the comprehensive Statement of  
8 Material on the industry prepared by the Director  
9 of Investigation and Research under the Combines  
10 Investigation Act. However, we have indicated  
11 briefly the particular impact of drug sales in  
12 Saskatchewan as compared to Canada as a whole. In  
13 addition, we have outlined recent experience in  
14 drug purchasing by the Department of Public Health  
15 in this province and indicated in some detail the  
16 prices paid for various products. We are confining  
17 the submission almost exclusively to drugs sold under  
18 prescription.

19 New Role for Drugs and the Industry  
20

21 The importance of this investigation  
22 is enhanced by what appears to be not only an  
23 increased role for drugs in medical care but a funda-  
24 mental transformation of that role in the last two  
25 decades and a profound change in the nature of the  
26 drug industry itself. From an essentially ameliora-  
27 tive role in treating illness, drugs have come to  
28 occupy a central curative position. In many cases  
29 we have seen the development of products of astoni-  
30 shing and miraculous power. This advance has come





1 about almost exclusively in the category of drugs  
2 available only on prescription. At the same time  
3 the pattern by which most prescription drugs were  
4 compounded by the pharmacist from the basic chemi-  
5 cals has been changed to one where a high propor-  
6 tion of these drugs are formulated by large pharma-  
7 ceutical houses. For instance, it is indicated that  
8 in the United States "whereas in 1939, 80 per cent  
9 of prescriptions were compounded by the druggist on  
10 the premises, now at least 90 per cent are prefabri-  
11 cated by pharmaceutical houses". ("American Journal  
12 of Public Health", May 1961, p. 647, "The Clinical  
13 Value of Drugs: Sources of Evidence" by Dr. Mindel C.  
14 Sheps).

15  
16 All of this has very substantially  
17 enhanced the economic position of the drug manufac-  
18 turing industry. This is particularly so since the  
19 market for prescription drugs is a rather unusual one  
20 in which the person who makes the choice of product  
21 is not the one who pays for it. Thus, market forces  
22 which have sometimes operated, albeit imperfectly,  
23 to reduce prices that were out of line have little or  
24 no effect on the prices of prescription drugs.  
25 Indeed, in what has become by its very nature a most  
26 lucrative field of business, there have been distur-  
27 bing signs of an increasing commercialism in its  
28 worst sense with an enormous proliferation of almost  
29 6,000 new pharmaceutical products in the last 12  
30



1 years of which less than 10 per cent have been new  
2 chemical entities and perhaps less than 5 per cent  
3 have been new original products. (ibid., pp. 648-  
4 649).

5  
6 As was stated before the 1960 annual  
7 meeting of the American Public Health Association,  
8 "the huge volume of prescription products is pro-  
9 duced and marketed in the same atmosphere that pro-  
10 duces a rapid turnover in automobile models and  
11 women's styles. Despite exceptions, premature and  
12 excessive promotion of drugs, inadequate investiga-  
13 tion, and unnecessary, confusing duplication are  
14 common". (ibid., p. 653). It is this particular  
15 aspect of the drug industry and the unfortunate  
16 consequences that flow from it that, in our view,  
17 urgently require public action.

18 We believe that there must be a funda-  
19 mental change in the philosophy and approach of the  
20 drug industry. It seems to us as inappropriate for  
21 exorbitant profits to be made out of the need of  
22 sick people for curative drugs as it would be to  
23 demand a ransom from the dying for blood plasma.  
24 It seems to us as ethically wrong to promote by  
25 high-pressure commercial methods the use of certain  
26 drugs as it would be to operate other health ser-  
27 vices and facilities on a purely commercial basis.  
28 In our view, the whole field of health care is so  
29 vital that the best practices of medical science  
30





1 must be allowed full sway without being warped by  
2 commercial importuning from outside. We find it  
3 more than a little alarming to realize that perhaps  
4 a significant number of the drugs now in wide use  
5 have come onto the market before adequate testing  
6 partly as a result of the strong commercial drive  
7 of the drug houses. We are anxious to see that the  
8 very considerable economic power of the industry is  
9 not allowed to distort sound medical practice. There  
10 can be little doubt that the proper health care of  
11 the nation is involved.  
12

13               Therefore, our recommendations are  
14 directed primarily to reducing the power of commer-  
15 cial influences in the drug industry and assuring  
16 that drugs shall be developed and used in a more  
17 disinterested atmosphere than that which now pre-  
18 vails. In our view, to achieve this will require  
19 broad measures of public control. In the past,  
20 public action has been confined largely to assuring  
21 that drugs are not positively harmful and have met  
22 established quality standards and that certain  
23 drugs should be available only on the prescription  
24 of a doctor. In addition, certain restrictions on  
25 advertising have prevailed. We think that public  
26 action should now be extended in a more positive  
27 manner, particularly through a greater degree of  
28 public scientific investigation and control and  
29 through measures by which the price of drugs might  
30



1 be kept at reasonable levels.

2 Increasing Drug Usage and Costs in Saskatchewan

3           It is difficult to measure statisti-  
4 cally the changing role of drug use in medical prac-  
5 tice. Nevertheless, estimates of prescription sales  
6 provide evidence of the increased cost of prescrip-  
7 tions sold. In as short a period as from 1954 to  
8 1959 prescription sales in Saskatchewan, according  
9 to the Canadian Pharmaceutical Association, have  
10 more than doubled from \$3.3 million to \$7.3 million  
11 following a Canada-wide trend. (See Appendix A,  
12 Table 1). The estimated per capita cost of pres-  
13 criptions sold in the province has climbed from  
14 \$3.84 in 1954 to \$8.06 in 1959. It is indicated  
15 that the per capita cost of prescriptions in  
16 Saskatchewan is somewhat above the Canadian average.  
17 (See Appendix A, Table 2).

18           It is also indicated that the portion  
19 of drug stores' retail sales that is going for  
20 prescriptions has been climbing in Saskatchewan  
21 as it has in Canada as a whole. (See Appendix A,  
22 Table 3).

23           The apparent general trend of drug  
24 costs is confirmed by the experience of provincial  
25 health programs in Saskatchewan making drugs  
26 available to the public, such as Program I of the  
27 Department of Public Health. Program I was esta-  
28 blished in 1945 to provide free drugs to long-term  
29  
30





1 beneficiaries of public assistance such as reci-  
2 pients of Old Age Security Pensions and Blind  
3 Persons' Allowances who qualify for the provincial  
4 supplemental allowances and recipients of Mothers'  
5 Allowances as well as their spouses and dependents.  
6 From December 1, 1948, a utilization charge of 20  
7 per cent of the cost of approved drugs was paid by  
8 the patient. As of April 1, 1959, this was  
9 increased to 50 per cent.  
10

11           The cost to the province of drugs  
12 supplied to Program I beneficiaries went up from  
13 \$3.12 per beneficiary in the 1945-46 fiscal year  
14 to \$16.62 in 1958-59. (The total cost of drugs per  
15 beneficiary in 1958-59 was close to \$21 since 20  
16 per cent of the cost was paid by the beneficiary).  
17 (See Appendix A, Table 4). Although drug expendi-  
18 tures on behalf of old age pensioners have been the  
19 highest, all three categories of recipients have  
20 exhibited similar trends in drug costs. This  
21 reflects increased utilization rates as well as  
22 increased average prescription prices. (See Appen-  
23 dix A, Table 5). While other programs have not been  
24 analyzed in this detail, it seems likely that the  
25 same pattern of usage is to be found there. This  
26 confirms the importance of a program to reduce drug  
27 costs. It should be noted that these prescription  
28 drugs are supplied through the ordinary channels and  
29 so the prices paid are probably representative of  
30



those paid by the public in the same age categories  
not covered by such assistance programs.

In addition there are public health  
programs in which the government purchases drugs  
directly, usually by competitive tender, from the  
manufacturer for purposes of patient supply.

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1 In Appendix B, we have indicated in  
2 some detail the nature of some of these programs  
3 and have noted some of the prices paid for various  
4 drugs required. The very substantial savings  
5 realized through this method of purchase as com-  
6 pared to the suggested retail price is apparent.  
7 For instance prednisone tablets (5 mg. per tablet)  
8 have been purchased for \$1.52 per bottle of 100 as  
9 compared with the suggested retail price of \$22.70,  
10 hydrocortisone tablets (20 mg. per tablet) have been  
11 purchased for \$5.00 per bottle of 100 as compared  
12 with the suggested retail price of \$29.80 and vita-  
13 min supplements have been obtained for prices ranging  
14 from one-third to one-seventh of suggested retail  
15 prices. It is apparent that these prices have been  
16 lower even than the wholesale prices to druggists  
17 since the normal trade discount to retailers is 40  
18 per cent off list price. (Material collected  
19 relating to the Manufacture, Distribution and Sale  
20 of Drugs by Director of Investigation and Research  
21 of Combines Investigation Act, p. 84).

22  
23  
24 If the cost of drugs continues to  
25 rise, it may well be necessary for governments to  
26 purchase directly a wider array of prescription  
27 drugs. However we believe there is much merit in  
28 a policy of utilizing the facilities provided by  
29 pharmacists and so we believe the question of drug  
30 prices should be attacked at the manufacturing level





1 with a view to obtaining reductions in prices to  
2 the pharmacists which could then be passed on to  
3 the public.  
4

5 Recommendations

6 As we have indicated our principal  
7 concern is with the changing of the fundamental  
8 approach of drug manufacturers. To this end we  
9 would recommend a broadening of public control  
10 along five general lines, first, to provide for  
11 greater inspection to provide greater assurance  
12 that drugs are of uniform quality and safety;  
13 second, to establish a national research laboratory  
14 to accomplish the two-fold purpose of analyzing  
15 existing and new drugs in order to make authorita-  
16 tive public reports and of conducting basic research;  
17 third, to set up a system of control over drug  
18 prices; fourth, measures to inhibit high-pressure  
19 promotion of drugs; and fifth, measures to encourage  
20 the wider use of generic names for drugs in the  
21 place of brand names.  
22

23 Expanded Inspection Procedures

24 We support the plea of Dr. Morrell,  
25 Head of the Federal Food and Drug Directorate  
26 before this Commission, for a considerably larger  
27 staff to enable a more thorough testing of drug  
28 products in Canada. Such a step would enable the  
29 generally less expensive drugs from less well-known  
30 manufacturers either in Europe or in Canada to be



1 used with greater assurance and through a measure  
2 of price competition result perhaps in very consi-  
3 derable savings.  
4

5 Establishment of a National Drug Research Laboratory

6 We believe that the establishment of  
7 a National Drug Research Laboratory is of fundamen-  
8 tal importance. This might function as a part of a  
9 Medical Research Council if deemed advisable.

10 We would urge that the Food and Drug  
11 Act should be amended to provide that no drug may  
12 be sold in Canada until it has received a certificate  
13 from the National Drug Research Laboratory not only  
14 that it will not harm the patient but that it is  
15 beneficial and is needed. We make this recommenda-  
16 tion specifically because it appears to us that a  
17 large part of present so-called drug research is  
18 directed to the development of drugs varying only  
19 slightly from that of related drugs thus adding to  
20 the pharmaceutical confusion without contributing  
21 to the advancement of medicine. This requirement  
22 has been followed with some success in keeping the  
23 number of registered drugs under reasonable control  
24 in other countries such as the Scandinavian  
25 countries (Dr. Karl Evang, "Health Service, Society  
26 and Medicine", Oxford University Press, 1960, pp.  
27 127-128) and seems appropriate for Canada. We  
28 would urge the Commission to study the experience  
29 of these countries. We think that such a National  
30



1 Laboratory should scrutinize very closely formulae  
2 of compound preparations. In addition, we make  
3 this recommendation because of our conviction that  
4 many drugs are coming onto the market before all the  
5 clinical qualities of the drugs have been established.  
6 We would note that unexpected side-effects of the  
7 use of what had been thought to be harmless drugs  
8 have materialized upon extended use. We believe  
9 that the public in these cases have been provided  
10 with inadequate protection.

12 As the name implies, the other function  
13 of the proposed National Drug Research Laboratory  
14 would be to conduct drug research. We are aware of  
15 the very useful reserach conducted by the drug manu-  
16 facturers themselves and we would not want to inhibit  
17 the development of desirable research programs. We  
18 feel, however, that this can be very well supplemented.  
19 In any event it has been indicated that the research  
20 being carried on in Canada by drug manufacturers is  
21 "relatively limited". (Material collected relating  
22 to the Manufacture, Distribution and Sale of Drugs  
23 by Director of Investigation and Research of Combines  
24 Investigation Act, p. 140). In addition there are  
25 indications that a great deal of research by the  
26 industry is duplicative-designed in essence to juggle  
27 the molecules of a product a little just to be able  
28 to turn over a new drug for the high-pressure selling  
29 campaign of the marketing division. In addition,  
30





1 once a new drug has been discovered, much research  
2 is devoted to discovering other means of manufac-  
3 turing it or producing other derivatives and  
4 congeners that add little to medical knowledge or  
5 more efficacious treatment.  
6

7 We feel there is a need for a national  
8 research laboratory not only to conduct research  
9 for the purpose of developing new drugs but to study  
10 and publicize the multifarious side-effects of  
11 existing drugs so that safer treatment methods  
12 might be adopted. We do not envisage this being  
13 done only in one central agency. Rather we would  
14 suggest that central research facilities should be  
15 established but that grants should also be made  
16 available on a more generous basis for particular  
17 studies to universities, hospitals and other agen-  
18 cies, public or private, of competence in the field.

19 Control over Drug Prices

20 In our view, an abundance of evidence  
21 has been supplied both in the study by the Kefauver  
22 Committee in the United States and in the study by  
23 the Director of Investigation and Research of the  
24 Commission to justify a conclusion that drug prices  
25 in many instances are unreasonably high. The really  
26 startling price margins cited in specific instances  
27 seem to be only the more striking examples of what  
28 appears to be a wide-spread practice in the industry.  
29 We suggest that it has been possible for the large  
30



1 margins between cost and selling prices to be  
2 maintained over a long period of time because of  
3 the special character of the product supplied and  
4 the market served as well as the factor of patent  
5 rights over drugs or methods of manufacture. There-  
6 fore we believe that special measures to control  
7 drug prices are justified.  
8

9 We note that the authority of the  
10 Commission itself is mainly limited to taking  
11 action against firms that have been engaged in  
12 restrictive trade practices. There would appear to  
13 be very considerable difficulties in establishing  
14 overt evidence of any formal combine or agreement.  
15 In our view, such a combine would not be required  
16 to maintain the present price structure. In a  
17 situation where price reductions would not lead to  
18 increased sales nor price increases lead to reduced  
19 sales there is no incentive for the industry as a  
20 whole to reduce prices. Further, in an industry  
21 dominated by a few firms, there is little incentive  
22 for an individual firm to seek to undercut its  
23 competitors. Thus we would suggest that drug prices  
24 probably are maintained primarily by informal  
25 methods rather than by formal conspiracies to set  
26 prices and the methods usually available to the  
27 Restrictive Trade Practices Commission may not be  
28 able to accomplish the end of lower drug prices.  
29

30 We think therefore, that there should



1 be a continuing survey of drug prices by a federal  
2 drug prices tribunal designed to consider, and hold  
3 hearings on, specific complaints of overly-high  
4 prices, to consider measures by which they might be  
5 reduced and to recommend the maximum price level.  
6 It might be advisable for this agency to have the  
7 power to recommend the loss of patent rights in  
8 Canada where the price of a drug has been established  
9 as inordinately high.  
10

11 Methods to Deal with High-Pressure Promotion

12 In our view, the advertising and  
13 promotion of drugs has gone beyond the bounds of  
14 propriety and common sense. It has been clear for  
15 some time that advertising and promotion has become  
16 one of the major costs of doing business and this  
17 has been confirmed by the material published by the  
18 Commission. (ibid., p. 115). It would seem there-  
19 fore that it is important to consider methods by  
20 which this might be reduced.  
21

22 It would be comparatively simple to  
23 rule that only expenditures on advertising and  
24 promotion up to a set portion of sales could be  
25 regarded as legitimate business expenses for  
26 income tax purposes. This might be deemed to be a  
27 variant of a system of price control in effect in  
28 New Zealand where only a limited allowance is made  
29 for such expenditures in the controlled final  
30 price of drugs. (T.L. Hayes, "Prescribing in New





1 Zealand", Department of Health, New Zealand, p. 7).

2 This at any rate would constitute one approach to  
3 the problem.  
4

5 Another approach would be to set more  
6 stringent regulations regarding the type of adver-  
7 tising and promotion permitted.

8 It may also be suggested that really  
9 effective control over drug prices would probably  
10 have a greater effect in reducing unreasonably high  
11 promotion expenditures than almost any other step.  
12 In addition, steps to reduce the artificial prolife-  
13 ration of drugs would reduce promotional and adver-  
14 tising pressures.

15 Adoption of Generic Names for Drugs

16 We believe there is a very strong  
17 argument for the use of generic names for drugs  
18 rather than trade names. We believe this is impor-  
19 tant not only because of the possibility this would  
20 bring of introducing more price competition into the  
21 market and thus perhaps reducing prices but because  
22 it would eliminate a good deal of the present diffi-  
23 culties posed for doctors both in prescribing and  
24 in mastering the full range of new drugs available.  
25 How closely trade names are bound up with the  
26 commercialized approach of the drug manufacturers  
27 is indicated by the dire warning by the General  
28 Counsel of one of the United States companies that  
29 the use of drug generic names is a step to  
30



1 "socialized practice in medicine". ("The Workings  
2 and Philosophies of the Pharmaceutical Industry",  
3 p. 120).  
4

5 We believe the most effective step  
6 in this regard would be to adopt regulations in  
7 regard to advertising and labelling specifying  
8 that in both the generic name of a drug must be  
9 given major prominence and that the trade name, if  
10 any, may only be given minor attention. It would  
11 also seem appropriate here to recommend that the  
12 ingredients of patent medicines should be given  
13 fully in advertising and labelling.

14 Other Recommendations

15 We would urge the elimination of the  
16 11 per cent federal sales tax on prescription  
17 drugs. We would note that prescription drugs are  
18 exempt from Saskatchewan's 3 per cent sales tax.  
19 Further, we recommend a close examination of the  
20 effect of customs duties on drug costs in Canada.

21 Conclusion

22 In conclusion, we believe that the  
23 problems of drug prices and of the drug industry  
24 are of national scope and accordingly effective  
25 action can only be taken on the national level. We  
26 offer our suggestions for possible courses of  
27 action from this point of view with the aim of  
28 promoting the welfare of all Canadians.  
29  
30



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770

APPENDIX A

Table 1

Estimated Prescription Sales, Canada and Provinces, 1954-1959

<u>Year</u>	<u>Canada*</u>	<u>Maritimes</u>	<u>Quebec</u>	<u>Ontario</u>	<u>Manitoba</u>	<u>Saskatchewan</u>	<u>Alberta</u>	<u>British Columbia</u>
1954	\$ 68,705,499	\$ 5,373,205	\$13,636,746	\$22,346,643	\$3,938,194	\$3,349,012	\$ 5,217,441	\$ 7,499,166
1955	74,149,181	5,767,224	16,244,566	26,209,342	4,340,708	4,302,334	5,331,306	9,157,791
1956	87,404,881	6,437,704	23,126,241	34,092,483	4,436,690	4,984,913	6,056,788	9,927,592
1957	102,185,569	8,294,685	24,197,146	38,929,377	6,134,666	6,023,285	7,422,080	11,404,549
1958	111,575,365	9,708,258	29,475,398	43,321,448	5,393,410	6,921,981	8,161,676	11,896,697
1959	130,867,037	11,601,089	34,017,310	47,663,359	6,057,294	7,268,799	11,847,033	14,540,294

\*Excluding Yukon and Northwest Territories.

Note: Based on Canadian Pharmaceutical Association\* figures for total retail trade and on their estimated ratios of prescription sales to total retail sales.





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771

Table 2  
Per Capita Cost of Prescriptions, Canada and Provinces, 1954-1959

Year	Canada*	Maritimes	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
1954	\$4.50	\$3.14	\$3.11	\$4.37	\$4.79	\$3.84	\$4.94	\$5.79
1955	4.73	3.32	3.60	4.98	5.17	4.90	4.89	6.82
1956	5.45	3.65	5.00	6.31	5.22	5.66	5.39	7.10
1957	6.17	4.63	5.03	6.92	7.13	6.85	6.40	7.67
1958	6.56	5.32	6.04	7.47	6.20	7.80	6.87	7.71
1959	7.52	6.25	6.80	8.01	6.84	8.06	9.53	9.26

\*Excluding Yukon and Northwest Territories.

Note: Based on the estimated prescription sales computed from figures supplied by the Canadian Pharmaceutical Association.



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772

Table 3  
Ratio of Prescription Sales to Total Retail Sales, Canada and Provinces, 1951-1959

Year	Canada*	Maritimes	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia
1951	15.1	24.0	18.3	8.9	11.9	20.7	20.9	25.4
1952	18.2	20.7	19.1	9.8	12.8	22.1	14.7	38.7
1953	16.3	19.8	21.0	13.8	26.5	21.1	17.0	16.0
1954	19.8	22.8	22.8	14.1	22.7	20.2	21.9	18.0
1955	19.9	25.0	24.5	16.1	21.6	21.5	20.5	20.0
1956	22.1	23.8	25.1	13.3	22.0	25.8	24.6	20.5
1957	23.7	27.6	27.1	20.7	25.9	28.1	25.4	21.2
1958	23.6	27.8	27.7	20.6	24.0	28.2	24.7	21.0
1959	26.0	28.9	30.6	23.2	26.3	29.1	30.8	23.7

\*Excluding Yukon and Northwest Territories

Source: Canadian Pharmaceutical Association annual surveys.



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773

Table 4  
Expenditures for Drugs and Appliances, Program I, Saskatchewan  
Fiscal Years, 1945-46 to 1958-59

Year	All Beneficiaries		Old Age Pension		Mothers' Allowance		Blindness Allowance	
	Total	Per Benef.	Total	Per Benef.	Total	Per Benef.	Total	Per Benef.
1945-46	\$ 76,600 <sup>1/</sup>	\$ 3.12	\$ 62,000	\$ 4.17	\$10,900	\$1.27	\$1,700	\$ 3.84
1946-47	111,300 <sup>1/</sup>	4.24	89,000	5.58	19,500	1.97	2,800	6.09
1947-48	133,100 <sup>1/</sup>	5.12	108,900	6.76	21,000	2.47	3,200	6.53
1948-49	172,900	6.24	137,900	7.76	30,500	3.27	4,502	7.54
1949-50	146,600	5.06	117,300	6.24	23,400	2.67	3,900	5.86
1950-51	161,127	5.35	-	-	-	-	-	-
1951-52	199,717	6.47	-	-	-	-	-	-
1952-53	230,968	7.72	-	-	-	-	-	-
1953-54	252,563	8.27	213,360	10.69	35,046	4.13	4,157	7.18
1954-55	281,448	9.68	237,068	11.90	40,120	4.68	4,280	7.35
1955-56	340,052	11.58	285,861	14.71	49,209	5.23	4,982	9.53
1956-57	339,748	11.72	283,915	14.77	50,517	5.47	5,316	9.94
1957-58	414,118	14.59	349,934	18.12	57,078	6.68	7,106	13.16
1958-59	466,410	16.62	399,490	20.51	59,567	7.42	7,353	13.32

- 1/ Estimates calculated using per beneficiary expenditures and average number of beneficiaries per year.  
2/ Effective December 1, 1948, the beneficiary became responsible for 20 per cent of the cost of prescriptions dispensed by drug stores.  
3/ This accounts for the drop in total department expenditures for drugs and appliances in 1949-50 as compared with the previous year.  
4/ Breakdown of expenditures by category of public assistance beneficiary not available.  
5/ Payment on behalf of old age security (supplementary allowance) beneficiaries since 1952-53.

Source: Saskatchewan Department of Public Health, Health Survey Report; Vol. 1, Health Programs and Personnel, Annual Reports, and Medical Services Division Statistical Tables.





Table 5  
Expenditures for Drugs and Appliances,  
Program I, Saskatchewan  
Fiscal Years 1949-50 to 1958-59

<u>Fiscal Year</u>	<u>Per Capita Expenditure<sup>1/</sup></u>	<u>No. of Prescriptions Per Capita</u>	<u>Average Cost Per Prescription (at 80 per cent of Charge)<sup>2/</sup></u>
1949-50	\$ 5.06	3.5	\$1.30
1950-51	5.34	3.8	1.38
1951-52	6.47	4.2	1.51
1952-53	7.72	4.6	1.61
1953-54	8.27	4.9	1.70
1954-55	9.68	5.3	1.82
1955-56	11.58	5.8	2.00
1956-57	11.72	5.9	2.07
1957-58	14.59	6.8	2.13
1958-59	16.62	7.3	2.27

<sup>1/</sup> Calculated on the amount paid for prescriptions dispensed by drug stores and physicians which is equivalent to 80 per cent of the full assessed price. 20 per cent is paid by the patient as a utilization charge.

Source: Saskatchewan Department of Public Health, Health Survey Report; Vol 1, Health Programs and Personnel, Annual Reports, and Medical Services Division Statistical Tables.



APPENDIX B

SASKATCHEWAN GOVERNMENT EXPERIENCE IN DRUG PURCHASING

Generally speaking, drugs are purchased on a tender basis through the Purchasing Agency where this is feasible. The principal Public Health Department Agencies involved are Medical and Hospital Services Branch (Medical Services Division), Regional Health Services Branch (Communicable Diseases Division) and Psychiatric Services Branch (Institutions).

1. Medical Services Division

Purchases of selected items are made for distribution to Provincial Public Assistance cases whose health care is the responsibility of the Division. The principal drugs concerned are Anti-Diabetic Agents, Pernicious Anemia Therapy, Cortico Steroids, Adrenocorticotrophic Hormone and Vitamin Supplements. The table attached lists most of the drugs purchased together with information on quantities purchased, cost prices per unit and suggested retail prices.

(a) Anti-Diabetic Agents

(1) Insulin is purchased from only two companies who are the main regular suppliers of this drug. To facilitate having fresh supplies, orders are placed on an emergency order basis.

(2) Tolbutamide - This was originally



1  
2 available only from Companies D and  
3 E, who submitted identical bids of  
4 \$2.50. Both these companies later  
5 reduced the price to \$2.40. Subse-  
6 quently Company C bid \$1.60. This  
7 resulted in a bid of \$2.16 from  
8 Company D. The product of Company C  
9 is now stocked routinely.

10  
11 (3) Chlorpropamide and Phenformin -  
12 Only one supplier for each of these  
13 has come to light to date so no  
14 competitive bidding has occurred.

15 (b) Pernicious Anemia Therapy

16 This involved purchases of Injectable  
17 Liver Extract and Injectable Vitamin B<sub>12</sub>.  
18 Quotations were originally sought from  
19 several companies and the lowest chosen.  
20 Because of the patient acceptance problem,  
21 no attempt has been made to change sup-  
22 pliers. It is felt that the present costs  
23 are not likely to be improved significantly.  
24 Original quotes ranged from 65¢ to 75¢ for  
25 Injectable Vitamin B<sub>12</sub> - 30 mcg. and 95¢ to  
26 \$1.36 for 100 mcg. In the case of Injec-  
27 table Liver, the quotes ranged from \$1.76  
28 to \$3.54. The prices of Injectable Vita-  
29 min B<sub>12</sub> have been substantially reduced  
30 during the last few years.



1  
2 (c) Cortico Steroids

3 Comparative bids were experienced in  
4 the case of Prednisone, Prednisolone and  
5 Triamcinolone. Bids from two different  
6 companies for Prednisone 5 mg. tablets were  
7 \$2.80 and \$1.52½. For Prednisolone 5 mg.  
8 tablets they were \$14.00 and \$5.70. For  
9 Triamcinolone, they were \$7.85 and \$9.33  
10 for the 2 mg. tablet and \$15.70 and \$17.27  
11 for the 4 mg. tablet.

12 (d) Vitamin Supplements

13 After agreement was reached with the  
14 doctors using these preparations, competi-  
15 tive bidding was sought and a product for  
16 which \$1.10 had been paid was obtained for  
17 50¢.  
18

19 2. Regional Health Services Branch

20 Communicable Disease Control Division

21 As the greater percentage of drugs  
22 used in this division are manufactured only by  
23 Company A, tenders are not usually requested, there  
24 being just the one agency to purchase from.

25 Sodium Fluoride tablets are manufactured  
26 by special arrangement at the University Hospital,  
27 Saskatoon, a tender being submitted for the year's  
28 supply.

29 Oral Penicillin tablets until recently  
30 were purchased from Company S, this company





1 manufacturing a tablet containing 444,250 units,  
2 whereas the tablets manufactured by other companies  
3 contained only 400,000 units. Recently it was  
4 decided that the tablet with the smaller amount of  
5 units was suitable in the Rheumatic Fever program  
6 and as a result tenders have been called for and  
7 the lowest accepted.

8  
9 Venereal Disease Control Division

10 Penicillin is the main drug purchased  
11 by this division and the company quoting the lowest  
12 price is usually dealt with. At the present time  
13 this is Company X. Other antibiotics are purchased  
14 sparingly, they being used only in instances where  
15 penicillin, for one reason or another, is not indi-  
16 cated.

17 Efforts are made at all times to pur-  
18 chase drugs at the lowest price, provided items  
19 meet requirements.

20  
21 3. Psychiatric Services Branch

22 No detailed analysis has been made at  
23 this time of invoices of drug purchases. The  
24 experience of the branch has been that in the last  
25 three years they have been able to purchase certain  
26 pharmaceuticals, chlorpromazine for instance, from  
27 one company at about one-third of the price that  
28 had previously been paid to other companies.  
29 During this period there has been no indication of  
30 a difference between chlorpromazine from this source  
and more expensive sources.



PHILIP M. BUCKLE, M.D., M.P.H., M.A., F.A.C.P., F.A.P.A., F.A.S.P.

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SALES PURCHASING BY THERMAL DISEASE CONTROL DIVISION

Drug	Strength	Supplier	Most recent invoice		Suggested Actual Price
			Date	Quantity	
Agona Fraction Penicillin "G"	10 c.c. (5,000,000 units)	Company Z	June 19, 1961	100 x 10 c.c. vials	n/a
Procidine Penicillin "G" in Oil with AR	1 c.c. (300,000 units)	Company U	June 6, 1961	50 x 1 c.c. vials	0.80
Crysanapine (Penicillin & Streptomycin)	Pen. .5 gm. Streptomycin .5 gm.	Company A	Aug. 11, 1960	100 x 2 c.c. vials	n/a
Chloramphenicol (Chloromycetin)	250 mg. capsules (16 caps. to a bottle)	Company J	Apr. 19, 1961	15 bottles	4.40
Chlortetracycline HCl (Aurcomycin)	250 mg. capsules (16 caps. to a bottle)	Company T	Apr. 19, 1961	50 bottles	7.50
Oxytetracycline (Terramycin)	250 mg. capsules (16 caps. to a bottle)	Company F	Oct. 17, 1960	50 bottles	9.50
Salicylic Acid	(tab. 7.2 gm) (1,000 to a bottle)	Company J	July 12, 1959	10 bottles	n/a
Gentian	(tab. 7.2 gm) (500 to a bottle)	Company V	Aug. 11, 1960	20 bottles	32.00





1 THE CHAIRMAN: Thank you, Mr. Erb.

2 One little question occurred to me on the last page  
3 when you speak of the ingredients of patent medi-  
4 cines. Are you referring to what are ordinarily  
5 called patent medicines, or drugs for which the  
6 manufacturer has obtained a patent. These are not  
7 the same things?  
8

9 HON. MR. ERB: A patent under the  
10 Patent Medicine Act.

11 THE CHAIRMAN: Did you wish to make  
12 any further comments Mr. Erb, at this time?

13 HON. MR. ERB: No.

14 THE CHAIRMAN: Mr. MacLeod, have you  
15 some questions that occur to you out of the brief?

16 MR. MACLEOD: Just one point occurs to  
17 me. It might be well to get clear the exact circum-  
18 stances in which the prescription is filled by the  
19 druggist and the druggist is paid by the hospital,  
20 and the other circumstances under which the Province  
21 buys the drugs, or contributes to the cost where it  
22 is purchased by a hospital or something like that.  
23 You spoke of Program 1. That applies to?

24 HON. MR. ERB: Old-age pensioners and  
25 people on supplementary allowances.  
26

27 MR. MACLEOD: Is it correct that in  
28 those cases these recipients take their prescription  
29 to a druggist, the druggist fills the prescription,  
30 and the Province bears all or part of the cost of



1 prescription?

2 HON. MR. ERB: That is right.

3 THE CHAIRMAN: All or part of the cost?

4 HON. MR. ERB: Part of the cost.

5 THE CHAIRMAN: It is now 50%?

6 HON. MR. ERB: In 1948 we put on cost  
7 to the pensioner, it is now 50%.

8 THE CHAIRMAN: I would suspect that  
9 the reason was that the cost to the Province was  
10 rising, is that right?

11 HON. MR. ERB: Yes, and increase in  
12 utilization as well.

13 THE CHAIRMAN: Another question which  
14 may be included in your appendices. In your brief  
15 you refer to the rapidly increased cost per capita,  
16 and you do mention increased utilization, and you  
17 refer to an increase which is not spelled out in  
18 the average cost per prescription. Is that spelled  
19 out in the appendices?  
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HON. MR. ERB: Yes, I am told so it is.

THE CHAIRMAN: That is a matter of an increase in the average cost of the prescription?

HON. MR. ERB: Yes.

MR. TOTTEN: That is Appendix A, Table 5.

MR. MACLEOD: Are these the only type of situations in which you pay the druggist directly for the prescription; in the case of the old-age pensioner or other social security people?

HON. MR. ERB: That is the only area in which we pay directly to the pharmacist.

DR. CLARKSON: Yes. In public assistance cases, including Program 2 as well as Program 1 but we emphasize Program 2. That is by far the largest proportion on the public assistance cases.

THE CHAIRMAN: You have emphasized Program 1.

DR. CLARKSON: Yes.

THE CHAIRMAN: What is Program 2?

HON. MR. ERB: Program 2 covers mental hospitals, jails.

DR. CLARKSON: Program 2 covers the wards and jail cases essentially. We pay those prescriptions. The beneficiary pays no part of those prescriptions.

THE CHAIRMAN: Before we proceed



1 further I think perhaps we would like to have the  
2 names of the officials and the position of each so  
3 we will have the record clear.

4 HON. MR. ERB: Mr. Totten is our  
5 Pharmaceutical Administrator, Department of Health.  
6 Dr. Clarkson is the Director of Medical Services  
7 Division. Mr. Carl Wenaas is with the Economic and  
8 Planning Advisory Board.

9 THE CHAIRMAN: Perhaps we should have  
10 the initials. You have given us Mr. Carl Wenaas.

11 HON. MR. ERB: J.G. Clarkson and  
12 Wilfred Totten.

13 MR. MACLEOD: When prescriptions are  
14 filled by a druggist and the cost is borne by the  
15 hospital, as in the cases you have mentioned, is  
16 payment made on a set scale?

17 MR. TOTTEN: It is made on the basis  
18 of a schedule of fees that has been agreed upon  
19 between the Department and the Pharmaceutical Asso-  
20 ciation. To that extent it is set. We regard  
21 this schedule as the maximum schedule.

22 MR. MACLEOD: What I had in mind was:  
23 if a prescription was written for drug "X" in  
24 Regina and some time later a prescription was written  
25 for the same drug in the same amount in Saskatoon,  
26 would the Government normally pay the same price  
27 to each druggist?

28 MR. TOTTEN: We would pay up to the  
29





1 same maximum, yes.

2 MR. MACLEOD: Has it been your expe-  
3 rience that the invoices submitted to you have  
4 shown the maximum prices under the schedule?  
5

6 MR. TOTTEN: Not as a routine.

7 MR. MACLEOD: Sometimes they are  
8 lower?

9 MR. TOTTEN: Sometimes they are  
10 lower, sometimes they are above.

11 MR. MACLEOD: Do you pay them when  
12 they are above?

13 MR. TOTTEN: No, we do not.

14 MR. MACLEOD: Was this schedule worked  
15 out as a result of discussions between the Government  
16 officials and officials of the Pharmacy Society?

17 MR. TOTTEN: That is right, sir.

18 THE CHAIRMAN: I was wondering when  
19 you called for tenders, I gather from what you said,  
20 you get varying prices. Is that correct?

21 MR. TOTTEN: Yes sir.

22 THE CHAIRMAN: Do you find that lower  
23 prices come from the same sources of supply in each  
24 case or nearly every case?

25 MR. TOTTEN: Not always, sir. Admit-  
26 tedly our experience has been somewhat limited. We  
27 have not found that to be the case.

28 THE CHAIRMAN: You have not seen any  
29 pattern?  
30



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MR. TOTTEN: No.

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THE CHAIRMAN: Sometimes one company will be lower. Sometimes another. You cannot distinguish any pattern?

MR. TOTTEN: That is right. We find that for specific products subsequent tenders usually follow this pattern, for specific products, but not related to companies for all their products. If you understand what I mean.

THE CHAIRMAN: I was going to ask one other question which arises out of the remarkable variation in prices for certain specific products that are mentioned on page 6; Prednisone and Hydrocortisone and Vitamin Supplements. These have been purchased and show a remarkable variation between the top and bottom prices.

Have you any record of the sources from whom these prices are obtained; those which are low and those which are high?

MR. TOTTEN: We have a table, sir.

THE CHAIRMAN: Is that shown on the table?

MR. TOTTEN: Yes sir. We did not identify the company as such but we show the comparative prices.

THE CHAIRMAN: Perhaps you might pursue that a little further. Are the higher prices usually from American companies or Canadian



1 subsidiaries or are they from European manufacturers?

2 MR. TOTTEN: I wouldn't be prepared to  
3 say there was any pattern there.

4 THE CHAIRMAN: You see no distinction  
5 between European manufacturers and American in terms  
6 of price?  
7

8 MR. TOTTEN: Not as a general rule in  
9 our experience. We had one instance where material  
10 that we purchased, and we presumed it was from a  
11 European source, was considerably lower than has been  
12 previously sold to Canadian manufacturers but this  
13 is one instance only that has come to our attention.

14 THE CHAIRMAN: Do you know which  
15 products come from European sources or do you simply  
16 buy from somebody in this country and perhaps not  
17 know the source?

18 MR. TOTTEN: We can't ever be sure of  
19 the source, sir. We buy from Canadian firms.

20 THE CHAIRMAN: The difference in these  
21 prices quoted on page 6 certainly is quite remarkable.

22 MR. TOTTEN: If I might just explain --

23 THE CHAIRMAN: That is the sort of  
24 thing with which we are concerned, to see why there  
25 should be such a big difference as is shown here.

26 MR. TOTTEN: If I might just explain  
27 a little further, sir. The price on Prednisone is  
28 \$1.52 and that is the price we pay in a bottle of 100.  
29 The \$22.70 is the suggested retail price.  
30



1  
2 THE CHAIRMAN: Yes. Even between the  
3 price to the Government and the retail price, I wouldn't  
4 have expected that much difference, not from the same  
5 source anyway.

6 We are concerned in trying to ascertain  
7 the reasons. Our Terms of Reference, as has been  
8 mentioned in your brief, have to do with questions  
9 of Restrictive Practices or what is described broadly  
10 as monopoly situations.

11 The reasons for great variations in  
12 price sometimes point in one of those directions.  
13 Therefore we are trying to ascertain, if we can, why  
14 there are these great differences in prices, such  
15 as you have quoted here.

16 In some instances we have heard that  
17 certain European products, notably I think it is  
18 from Italy, have been sold at a lower price, a  
19 substantially lower price than those manufactured in  
20 the United States or in Canada and that is partly  
21 due to the fact they have no patent control in  
22 Italy. That may have a very strong bearing on it.  
23 I wondered if you had any information as to what  
24 was the source of these very varied prices.

25 MR. TOTTEN: We have no definitive  
26 information on that, sir but in one case that I  
27 could mention, I am led to believe, I am quite sure,  
28 this came from a European source, presumably Italy.  
29 I have no definitive information on that.  
30





1 I may say that on that table in Appen-  
2 dix A where we show the companies, we designate them  
3 by code. If the Commission would like we could give  
4 you the key to that code, if you are interested.

5 THE CHAIRMAN: The Commission would be  
6 interested because it may be necessary. It would  
7 be helpful to us possibly in ascertaining whether  
8 your experience and others who buy in large quanti-  
9 ties is similar in respect to different companies  
10 and different sources of supply. I think it would  
11 help us to clear up that if we had the key to these  
12 companies.

13 would you give that to Mr. MacLeod.  
14 Thank you very much.

15 MR. CARIGNAN: I would like to ask a  
16 question with respect to the third recommendation,  
17 where you say that we set up a system of control  
18 over drug prices.

19 I wonder whether or not it is within  
20 the constitutional powers of the Federal Government  
21 to set up such a system of control? I would like to  
22 know if you have given any thought to this aspect of  
23 the problem?

24 HON. MR. ERB: I might say there it  
25 impinges something on the constitutional rights but  
26 I think there are already some things - I would ask  
27 Mr. Wenaas to elaborate on that.

28 MR. WENAAS: I would say that this



1 question was given rather a brief consideration and  
2 because of the possibility of doubts arising in  
3 regard to the constitutional power to fix drug prices,  
4 we worded the recommendation to recommend maximum  
5 drug prices and we left the question open to the  
6 tribunal as to the means by which the goal esta-  
7 blishing those maximum drug prices may be reached.

9 It is an impossible field to approach  
10 in such a way inasmuch as it would not be necessary  
11 to actually specify or actually fix the drug prices  
12 but perhaps in other ways there might be an encourage-  
13 ment to the company to lower their prices to more  
14 appropriate levels.

15 We think that the adverse public rela-  
16 tions that impinged upon the drug manufacturer, if  
17 one of his products was found to be selling at an  
18 exorbitantly high price, and they had not actually  
19 carried out the recommendation of the price tribunal,  
20 would probably encourage the company along the  
21 right direction.

22  
23 However, there is some doubt, certainly,  
24 about the constitutional power to actually fix the  
25 prices.

26 THE CHAIRMAN: You are not actually  
27 suggesting that the Federal Parliament might pass an  
28 Act fixing or providing for the imposition of a  
29 fixed price because, as Mr. Carignan rather had in  
30 mind, the phrase "civil rights" is still fairly



1 important in our constitution.

2 MR. WENAAS: No.

3 THE CHAIRMAN: Would any member of  
4 your group, Mr. Erb, care to make any further comment.  
5 I think we have had a very good explanation. We are  
6 very indebted to you for the care with which you  
7 have prepared your brief and for the suggestions  
8 that are made in it because if we come to the conclu-  
9 sion that the facts warrant action, the suggestions  
10 we get will be very important to us for the purpose  
11 of advising on the recommendations we may ultimately  
12 make to the Government.  
13

14 Is there any further comment anybody  
15 in your group would care to give?

16 HON. MR. ERB: No, I don't think so.

17 THE CHAIRMAN: Thank you very much,  
18 Mr. Erb, and gentlemen. Thank you very much for  
19 making a very definite effort in preparing this  
20 material and sending it to us.  
21

22 As far as the Commission is aware,  
23 Mr. Pepper, you are the only other one who has  
24 indicated any intention to make a presentation  
25 this morning. Would you come forward please?

26 Would you let us have the names of  
27 those who are with you and whether they are officers  
28 of the Association or practising pharmacists or  
29 whatever the position is.  
30

MR. PEPPER: My name is Alfred Pepper.



I operate a retail drugstore in Regina. I am presently President of the Saskatchewan Pharmaceutical Association. On my far left, Mr. S.E. Ramsay is a retail pharmacist from Carlyle, Saskatchewan and is the Vice-President of the Saskatchewan Pharmaceutical Association. Next is Professor J.L. Sommers, Professor of Pharmacy at the University of Saskatchewan, College of Pharmacy. He is Director of the Pharmaceutical Services of the University Hospital.

Next, Mr. Doug White, retail pharmacist from Saskatoon and a councillor - a member of the Council of the Saskatchewan Pharmaceutical Association.

On my right, Mr. Vern Jansen, the Registrar Inspector of the Saskatchewan Pharmaceutical Association.



1 May I bring you copies of my notes,  
2  
3 Mr. Chairman?

4 THE CHAIRMAN: Yes, certainly.

5 MR. PEPPER: Mr. Chairman, gentlemen  
6 of the Committee; the Canadian Pharmaceutical Associa-  
7 tion will be presenting material to this committee at  
8 a later date, they will present information on all  
9 phases of pharmacy in Canada and for that reason we  
10 propose to confine our remarks to the practice of  
11 pharmacy in Saskatchewan and then to attempt answers  
12 for any questions you may have.

13 Pharmaceutical services are provided  
14 by 310 Retail Pharmacies in 183 communities, inclu-  
15 ding six which operate as dispensaries only, without  
16 handling merchandise usually associated with retail  
17 drug stores. All hospitals provide drugs for their  
18 patients, 14 of them have dispensary service. There  
19 are 530 pharmacists serving in retail pharmacy, 37  
20 in hospital dispensaries and 40 who are employed as  
21 medical services representatives of manufacturing  
22 firms.  
23

24 Most pharmacies are open about 10  
25 hours per day, many suburban stores are open 12  
26 hours per day, but in all areas there is a round  
27 the clock service available by phoning pharmacists  
28 at their homes after hours. Some pharmacies have  
29 their business phone switched to their homes after  
30 hours.





1                   The Provincial Pharmacy Act is similar  
2  
3   to those of other provinces; it sets out the qualifi-  
4   cations for membership; makes provision for the  
5   election of a council to conduct the affairs of the  
6   Association and sets up regulations for the handling  
7   of various types of drug products. The Opium and  
8   Narcotic Drug Act and the Food and Drugs Act further  
9   govern the handling of drug products. Other acts  
10   having some bearing on the practice of pharmacy are  
11   the Proprietary and Patent Medicine Act; the Excise  
12   Act; Pest Control Products Act and some sections of  
13   the Criminal Code and the Indian Act.

14                  Pharmacy students are required to serve  
15   12 months apprenticeship and to take a four year  
16   course of studies at the College of Pharmacy in the  
17   University of Saskatchewan. Pharmacists from other  
18   provinces, or other countries are required to submit  
19   their qualifications to the Examining Board of the  
20   University of Saskatchewan, which may recommend that  
21   they be admitted on the strength of their qualifica-  
22   tions or may require them to write examinations.  
23   The enrollment of pharmacy students has up to this  
24   point, barely met the demand. There is a reluctance  
25   on the part of many young people to undergo a four  
26   year college course in pharmacy when remuneration,  
27   whether it be salary or returns from a business, is  
28   no greater than that of many undertakings which do  
29   not require University training.  
30



1                   We have estimated that the people of  
2 Saskatchewan use slightly more than three million  
3 prescriptions per year at an estimated value of  
4 eight million dollars; this does not include medi-  
5 cines used in hospitals. It is estimated that this  
6 adds another two million dollars to the drug bill  
7 in Saskatchewan. It will be noted that this figure  
8 suggests a per capita expenditure of more than \$8.00  
9 for prescribed medicine in Saskatchewan as opposed  
10 to a suggested national average of \$7.50, whichever  
11 is right, these averages do not present a very clear  
12 picture by themselves. They should be examined in  
13 the light of the suggestion that nearly 60% of the  
14 population use no prescriptions at all and about  
15 15% of the people use about 75% of all prescriptions.  
16 This would suggest that their average is about \$50.00  
17 per year.  
18

19                   If this type of calculation is of any  
20 interest to the committee one of my colleagues is  
21 prepared to pursue it a little further. I might say  
22 that, if you so allow, there are some changes in  
23 the prescription figures I just gave you.  
24

25                   Our experience at present is that  
26 approximately 10% of all prescriptions are compounded  
27 by the pharmacist and the remainder are ready made  
28 products which require only to be dispensed.

29                   THE CHAIRMAN: I see you agree with  
30 the Government brief on that point.



1  
2 MR. PEPPER: We do, yes. A check of  
3 drug products commonly used in Canadian Reference  
4 Books shows about 5500 listings, about half of these  
5 have two or more strengths and some of them have as  
6 many as twelve different forms of administration to  
7 make a total of about 12000 items plus about 400  
8 chemicals, tinctures, oils, extracts, ointment  
9 bases etc. A rough check in the Regina area indi-  
10 cates that most pharmacists carry about 4000 to  
11 6000 of these.

12 Generic names are not in common use  
13 in this area. Most pharmacists would welcome the  
14 use of generic names where a product can be so  
15 prescribed because it could greatly reduce the  
16 number of products we are required to carry. In  
17 theory this would also reduce the price but for the  
18 present, would have little effect because pharmacists  
19 will not take the risk of supplying medication unless  
20 they are convinced of its purity and potency. Like-  
21 wise physicians are not likely to prescribe by  
22 generic name until they have some assurance that all  
23 drug products have been properly produced. I think  
24 it is obvious if the recommendations made by the  
25 provincial government were introduced then there  
26 would be no problem over generic names at all.  
27 More than half of the drug products listed are  
28 combinations of drugs which would not readily lend  
29 themselves to generic description.  
30



1                   About 90% of prescriptions are for  
2 items produced ready for use. Our prices are  
3 primarily governed by the manufacturers price but  
4 each prescription is the private medication for one  
5 specific person and requires individual attention,  
6 this in turn requires a professional fee to cover  
7 the dispensing of each order; this fee is in addi-  
8 tion to the price of the drug and bears no relation-  
9 ship to the price of the drug, rather, it is dic-  
10 tated by the time and care required. It should be  
11 added that a prescription is not an item of trade  
12 that can be freely bought, sold or traded.

13  
14                   In our letter to you of June 1960 we  
15 provided full information on our pricing methods  
16 and rather than repeat this here, we will leave any  
17 further comments to come with your questions on  
18 this matter. We have examined suggested pricing  
19 methods across the country and find that most of  
20 them follow a similar pattern but that professional  
21 fees vary with the cost of doing business and we  
22 find that the average price in Saskatchewan is one  
23 of the lowest in Canada due to lower operating  
24 costs.

25  
26                   In checking a number of prescrip-  
27 tions it was found that prices are uniform only in  
28 so far as they apply to Provincial Government  
29 contracts (about 7% of that volume) - even then  
30 it seems from Mr. Totten's remarks that they are



1 not uniform - and that prices actually charged vary  
2 as much as 10%. Where the guide was used in  
3 pricing prescriptions it was found that gross mark  
4 up in terms of material only would be 44% in original  
5 containers, 54% for broken quantities of prepared  
6 products and 80% for compounded preparations  
7 requiring more time. These rates could be 2 to 3%  
8 higher for pharmacies buying direct from manufacturer  
9 in large quantities and would be about 10% lower for  
10 pharmacies buying through wholesalers.

11 THE CHAIRMAN: One question arises  
12 there. Referring to the gross mark up, are you  
13 including there the prescription fee?  
14

15 MR. PEPPER: No, that is cost of  
16 material.

17 THE CHAIRMAN: I just wanted to be  
18 sure.

19 MR. PEPPER: Oh, pardon me, it is  
20 cost of material compared with the final price  
21 which includes the prescription fee.  
22

23 In most pharmacies the volume of  
24 prescription business is not large enough to main-  
25 tain the business, and the pattern here is that  
26 many other items are sold and in this manner pharma-  
27 ceutical services are available in many locations  
28 which could not otherwise support a pharmacist.

29 The retail pharmacist is primarily  
30 concerned with the provision of a pharmaceutical





1 service which will produce results desired by the  
2 physician. We are always ready to co-operate with  
3 the medical and other health professions for the  
4 promotion of better public health.

5 It is our desire to co-operate fully  
6 with this committee and we will try to provide  
7 answers to any questions you may wish to ask; you  
8 may wish us to make a more detailed submission on  
9 some points. I should mention, that we have  
10 recently undertaken a survey, not yet completed,  
11 which should give us quite an accurate picture of  
12 the volume of prescription business in Saskatchewan  
13 as well as the volume of other items.

14 As we indicated in our opening  
15 remarks, this does not pretend to be the complete  
16 story of pharmacy in Saskatchewan. We felt that  
17 by the time the committee reached this area the  
18 members would have a clear picture of the informa-  
19 tion they want.

20 We thank you for hearing us and  
21 invite your questions.

22 THE CHAIRMAN: Thank you, Mr. Pepper.

23 I would like to say in the first  
24 place, since you have undertaken this survey  
25 mentioned on the last page, we would be glad to  
26 have a copy of the results when it is completed.

27 MR. PEPPER: In that respect you are  
28 probably aware that there has been a great deal of  
29  
30



1 discussion on medical care in Saskatchewan and for  
2 that reason we made this survey, and Professor  
3 Sommers has - it is not complete, and he can deal  
4 with the questions you may ask.

5  
6 PROF. SOMMERS: These projections are  
7 based on a survey which involved 300 questionnaires.  
8 The response was well over 40%, and when the final  
9 tally is made we feel we will have 50% of replies.  
10 In some 40% of the replies we have had we find that  
11 prescription volume for this Province is 2,000,720  
12 prescriptions at a cost of \$7,675,000. The total  
13 retail sales in pharmacy are \$27,280. Therefore  
14 prescription sales constitute 28% of the total  
15 sales in the pharmacies in this Province. The  
16 average prescription cost in 1960 was \$2.84, the  
17 average number of prescriptions three per indivi-  
18 dual.

19  
20 THE CHAIRMAN: You mean three per  
21 head of population in Saskatchewan, not for persons  
22 who get prescriptions?

23 PROF. SOMMERS: No, that is right.  
24 These are the preliminary figures which we have  
25 produced, and we will make sure you get a copy of  
26 the survey when it is completed.

27 THE CHAIRMAN: Thank you, Professor.

28 I was going to ask the basis on which  
29 the estimates on page 2 were arrived at, but I  
30 gather it is part of the survey which you were



1 conducting.

2  
3 PROF. SOMMERS: We originally had  
4 three rule-of-thumb methods. We projected the  
5 Provincial Government buying, and we took the  
6 national average and they all came to about eight  
7 million dollars.

8 THE CHAIRMAN: When you say "we have  
9 estimated", I would like to know how close it is  
10 to being accurate?

11 Perhaps Mr. MacLeod has some questions.

12 MR. MACLEOD: Perhaps just to get the  
13 record straight, you are a practising pharmacist,  
14 Mr. Pepper?

15 MR. PEPPER: Yes.

16 MR. MACLEOD: Where is your store  
17 located?

18 MR. PEPPER: In Regina.

19 MR. MACLEOD: So it would be a city  
20 store?

21 MR. PEPPER: A city store, yes.

22 MR. MACLEOD: And is it in suburban  
23 Regina or in the centre of the city?

24 MR. PEPPER: No, on the edge of the  
25 centre of the city. It is not suburban, but it is  
26 not city either.

27  
28 MR. MACLEOD: Is your location such  
29 that you normally receive a volume of prescription  
30 business comparable to stores in the centre of the



1 city?

2  
3 MR. PEPPER: No, it is not. It is not  
4 a very good example, because I moved my store from  
5 the centre of the city last year, at least I was  
6 forced to move, and I picked the closest location  
7 I could find. But the volume of business in that  
8 location is not comparable to the centre of the city.

9 MR. MACLEOD: You were located for a  
10 number of years in the centre of the city?

11 MR. PEPPER: Yes.

12  
13  
14 -

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30 -



G/dpw

1 MR. MACLEOD: So you have had experience  
2 in selling in the centre of the city.

3 THE CHAIRMAN: Perhaps the point would  
4 be, do you get proportionately to your total business,  
5 more prescriptions where your store is now located  
6 than you did when you were located in the centre of  
7 the city?

8 MR. PEPPER: No, about 20%. It would  
9 hold the same.

10 THE CHAIRMAN: The same in the centre  
11 of the city and where you are now?

12 MR. PEPPER: Yes.

13 THE CHAIRMAN: I sometimes think that  
14 maybe in a residential area there would be a larger  
15 proportion of prescriptions, but that might be  
16 wrong, because people like to get prescriptions at  
17 a local drugstore.

18 MR. PEPPER: That might be true. I think  
19 in Regina a great volume of prescriptions is done  
20 by stores in the immediate vicinity of the medical  
21 buildings, and the stores farther out and in the  
22 suburbs are not to be compared with the stores in  
23 the vicinity of the medical buildings.

24 MR. MACLEOD: Would these be the six  
25 referred to in your brief as operating dispensaries  
26 only?

27 MR. PEPPER: There are three in  
28 Regina, three in Saskatoon and one in Yorkton, so  
29  
30





1 my figure was wrong.

2  
3 MR. MACLEOD: And these stores do the  
4 bulk of their business in prescriptions?

5 MR. PEPPER: All their business is  
6 done in prescriptions, although I should add that  
7 they keep such items as dressings and surgical  
8 supplies, or did your question suggest that the  
9 bulk of their business was prescription?

10 MR. MACLEOD: That these stores, the  
11 bulk of their business would be prescriptions?

12 MR. PEPPER: That is right.

13 MR. MACLEOD: Is the suggested guide  
14 for prescription prices which was sent in to the  
15 Director of Investigation and Research by the  
16 Registrar in 1960 still in force?

17 MR. PEPPER: Well, I cannot say that  
18 it ever was in force. It is used by a great many  
19 people, and variations of it are used by a good  
20 many people, and there are still people who have  
21 their own systems.

22  
23 MR. MACLEOD: What is the professional  
24 fee upon which the prices set out in the guide are  
25 based?

26 MR. PEPPER: 75 cents.

27 MR. MACLEOD: And that is regardless  
28 of the cost of the prescription?

29 MR. PEPPER: That has no bearing on  
30 the cost of the prescription. I should add that



1 there are two fees. 25 cents is the fee for an  
2 original package. If the package has to be broken,  
3 then 75 cents. We break it down and consider the  
4 cost of the container as 10 cents, the breaking fee  
5 15 cents and the professional fee 15 cents, total  
6 75 cents, but in the case of an original package  
7 25 cents.  
8

9 THE CHAIRMAN: What is your profes-  
10 sional fee where you actually do the compounding  
11 yourself?

12 MR. PEPPER: It varies with the time  
13 required. We have set out the average ointment fee  
14 in the vicinity of \$1. Likewise dispensing eye-drops  
15 and mixtures. It depends on the number of ingredients  
16 and the amount of time. It is a rule-of-thumb incor-  
17 porating the number of ingredients and the amount of  
18 time spent.

19 MR. MACLEOD: Do you know whether your  
20 members adhere very closely to that professional  
21 fee?  
22

23 MR. PEPPER: Not very closely, no.  
24 We attempted to find out in a very quick survey this  
25 last week, and asked prices on five different items  
26 in 23 different stores, and in the case of a  
27 compounded item, I think the answer was 12 different  
28 prices, or 14 different prices, ranging from \$2.00  
29 to \$3.00 on a bottled prescription. On the ready-  
30 made products, on a tablet from 22 stores there were



1 8 different prices, from \$3.50 to \$3.80.

2  
3 THE CHAIRMAN: Is that a prepared  
4 tablet?

5 MR. PEPPER: Yes, breaking the package.  
6 Another one using the original package, four  
7 different prices from \$11.90 to \$12.25. Using a  
8 ready-packaged ointment we have four different  
9 prices ranging from \$1.85 to \$2.10. On the big  
10 mixture, 23 stores, 15 prices ranging from \$1.80 to  
11 \$2.80.

12 MR. MACLEOD: Going back to what I  
13 was asking a moment ago, I am not too clear. If  
14 the manufacturer's original package does not have  
15 to be broken in filling a prescription, is the  
16 professional fee, or the fee that you add, 75 cents?

17 MR. PEPPER: 25 cents if it does not  
18 have to be broken.

19 MR. MACLEOD: If it has to be broken, .  
20 it is 75 cents?

21 MR. PEPPER: That is right.

22 MR. MACLEOD: Is there any limit, any  
23 upper limit to the price to which this will apply?

24 MR. PEPPER: There was never any  
25 suggestion that there would be, but I think it has  
26 become a common practice to eliminate that in the  
27 higher ranges.  
28

29 MR. MACLEOD: Does the guide suggest a  
30 minimum fee?



1 MR. PEPPER: No. Except in this  
2 respect, that inasmuch as it is fairly generally  
3 established that there is an approximate cost of  
4 \$1.04 in this, or in the handling of this prescrip-  
5 tion, there is a cost of 9¢ to 75¢.

7 MR. MACLEOD: Is that set out?

8 MR. PEPPER: No, it was originally,  
9 but it has not been observed closely. That is a  
10 minimum price.

11 MR. MACLEOD: The Saskatchewan Pharma-  
12 ceutical Association is the statutory body, of  
13 course?

14 MR. PEPPER: Yes.

15 MR. MACLEOD: Do you have any other  
16 association of retail druggists in the Province of  
17 Saskatchewan?

18 MR. PEPPER: Yes, a retail druggists'  
19 association.

20 MR. MACLEOD: What is the name of  
21 that?

22 MR. PEPPER: The Saskatchewan Retail  
23 Pharmacists' Association.

24 MR. MACLEOD: S.R.P.A.?

25 MR. PEPPER: Yes.

26 MR. MACLEOD: Do you have any local  
27 associations, for instance in the City of Regina?

28 MR. PEPPER: In the City of Regina we  
29 have on paper a retail druggists' association. As  
30



1 I recall, the last meeting was about June of 1959.  
2 June or July or maybe May. In Saskatoon --

3 MR. WHITE: We have a local association.  
4 Mr. Walker is the President of our Saskatoon group  
5 this year. We elect a new President and officers  
6 each year. It is a little local group we have to  
7 discuss things in our own city.

8 MR. PEPPER: I think it is general in  
9 most cities.

10 MR. MACLEOD: Has there been a  
11 discussion of the prices that should be charged for  
12 prescriptions at meetings of the local association  
13 in Regina?

14 MR. PEPPER: Yes, when this guide was  
15 first proposed it was discussed at a meeting. There  
16 were about 40 people there and 40 different opinions  
17 as to its value.

18 MR. MACLEOD: To your knowledge, did  
19 the local group at any time sponsor a schedule of  
20 its own for the use of its members?

21 MR. PEPPER: No, some members of the  
22 local group did make recommendations towards the  
23 building of this schedule.

24 MR. MACLEOD: Is there any restriction  
25 in Saskatchewan as to incorporated companies carrying  
26 on the business of a drugstore or pharmacy?

27 MR. PEPPER: Yes, an incorporated  
28 company, a majority of its directors must be  
29  
30





1  
2 pharmacists.

3 MR. MACLEOD: Do you know if when that  
4 legislation was introduced exceptions were made for  
5 companies which might have been carrying on for  
6 years, such as the T. Eaton Company?

7 MR. PEPPER: Yes, that is correct.  
8 It was in 1936, and of course any companies that had  
9 previously been in business were allowed to carry on.  
10 The same thing applied to the estate of an individual.  
11 The estate was allowed to carry on the business  
12 provided it complied with the regulations of the  
13 Pharmacy Act.

14  
15 THE CHAIRMAN: Does that mean that at  
16 the present time a company like Eaton's or Simpson's  
17 is, because it was previously operating a pharmacy,  
18 entitled to continue?

19 MR. PEPPER: Yes.

20 THE CHAIRMAN: But if another depart-  
21 mental store was established in Regina it would not  
22 be able to?

23 MR. PEPPER: Unless it has a majority  
24 of pharmacists in its directorate.

25 THE CHAIRMAN: I would like to think  
26 that pharmacists would be in a position to be in the  
27 majority, but usually that is not the case in  
28 departmental stores?

29 MR. PEPPER: No.

30 MR. MACLEOD: It means that stores



1 such as Safeway and Loblaws could not start a drug  
2 counter or dispensary?

3 MR. PEPPER: I would say no.

4 MR. MACLEOD: Does the Saskatchewan  
5 legislation contain certain restrictions on the sale  
6 of drugs, in the sense that certain drugs may only  
7 be sold through pharmacies?  
8

9 MR. PEPPER: Yes.

10 MR. MACLEOD: Would you indicate very  
11 generally what those restrictions are?

12 MR. PEPPER: It coincides pretty well  
13 with the Food and Drug regulations. We lay down  
14 that no person shall keep open shop for retailing,  
15 compounding drugs, or selling, except patent medi-  
16 cines, and listed are 35 household remedy types  
17 which may be sold by other outlets.

18 MR. MACLEOD: Do you have any restric-  
19 tions in Saskatchewan that if there is a drugstore  
20 within so many miles drugs cannot be retailed?

21 MR. PEPPER: No, we would consider  
22 that class legislation.

23 MR. MACLEOD: What types of drug pro-  
24 ducts or sundries may these other outlets sell?  
25

26 MR. PEPPER: Household medicines it  
27 lists here any patent medicines, it lists Borax,  
28 Epsom Salts and so on, and likewise nothing in this  
29 Act prevents a person not registered from selling  
30 or keeping for sale tincture of iodine, carbolic



1 acid not exceeding a certain strength. There are  
2 products which would contain arsenic or something  
3 of that nature, which would be limited by the Phar-  
4 macy Act, these are allowed.

5 MR. MACLEOD: It would come down to  
6 this, that patent medicines and common household  
7 remedies may be sold anywhere?

8 MR. PEPPER: Yes.

9 THE CHAIRMAN: Does that include the  
10 drug item, I suppose I should describe it as acetyl-  
11 salicylic acid?

12 MR. PEPPER: Officially, no. Do you  
13 remember, Mr. Ramsay? There was some legislation  
14 regarding aspirin in wartime, I should say ASA?

15 MR. RAMSAY: I don't know.

16 MR. JANSEN: My impression was that  
17 the Federal Government laid down that in areas where  
18 there were no drugstores, these drugs would be sold  
19 in any store.

20 MR. PEPPER: I think that was just a  
21 wartime measure.

22 MR. JANSEN: And that still carries  
23 on.

24 THE CHAIRMAN: The reason I asked that  
25 was because ASA is not a drug for which a manufac-  
26 turer can get a patent, and it is used very commonly  
27 and may be sold without a prescription. I wondered  
28 if it was included in your household remedies?



1 MR. PEPPER: We have begun to examine  
2 it again in the light of the acetylsalicylic acid  
3 poisons, but haven't decided what, if anything,  
4 should be done about it.  
5

6 MR. MACLEOD: Does your Association  
7 have a Code of Ethics?

8 MR. PEPPER: Yes.

9 MR. MACLEOD: Would you have a copy  
10 which you could file with the Commission?

11 MR. PEPPER: Yes, I would be glad to.

12 MR. MACLEOD: It appears to be  
13 phrased in very general terms.

14 MR. PEPPER: Very general, yes.

15 MR. MACLEOD: Does it make any refe-  
16 rence anywhere to a fair price?

17 MR. PEPPER: I think fair remuneration  
18 is the term.

19 THE CHAIRMAN: That sounds like fair  
20 profit rather than fair price.  
21  
22  
23  
24 -  
25  
26  
27 -  
28  
29  
30 -



/dpw  
1 MR. PEPPER: That is on one of the very  
2 early ones, am I right?

3 MR. MACLEOD: That is the "pharmacist  
4 should seek only fair remuneration for his services  
5 in the exercise of his skill and knowledge".  
6

7 MR. PEPPER: That is correct.

8 MR. MACLEOD: On occasion do complaints  
9 reach the Association about price cutting by indivi-  
10 dual druggists?

11 MR. PEPPER: I wouldn't say in the form  
12 of complaints. We have heard about it once in a  
13 while, as a matter of fact. Not on prescriptions,  
14 on newspaper ads. Were you referring to prescrip-  
15 tions only?

16 MR. MACLEOD: I was referring to  
17 generally. Do you get any complaints at all?

18 MR. PEPPER: I wouldn't say complaints.  
19 There is no reason - there is no point in complaining.

20 MR. MACLEOD: Do you have a committee  
21 of the Association which deals with such matters  
22 when information reaches you?

23 MR. PEPPER: No. Well, the Retail  
24 Pharmacists' Association would deal with it, if  
25 there was any measure within their power but I don't  
26 think there is right now.

27  
28 MR. MACLEOD: Well, you say there have  
29 been no complaints but information reaches the  
30 Association. Would this be the type of thing that





1 would be dealt with by the second association, that  
2 you mentioned?

3 MR. PEPPER: The second association,  
4 yes.

5 MR. MACLEOD: Are you an officer of  
6 that association?

7 MR. PEPPER: No I am not.

8 MR. MACLEOD: Are you a member?

9 MR. PEPPER: I am a member, yes.

10 MR. MACLEOD: Have you attended  
11 meetings?

12 MR. PEPPER: Yes. We have one meeting  
13 per year.

14 MR. MACLEOD: Have you heard pricing  
15 or practices of any particular retail pharmacist  
16 discussed at such meetings?

17 MR. PEPPER: No, never.

18 MR. MACLEOD: Do you know if such  
19 matters are discussed by any Committee of that  
20 Association?

21 MR. PEPPER: I don't think so. You  
22 could ask my colleagues. Mr. White, are you aware  
23 of any committee that discusses that?

24 MR. WHITE: No, I am not.

25 MR. PEPPER: Mr. Ramsay?

26 MR. RAMSAY: No.

27 MR. PEPPER: No, I don't think so.  
28 We take the attitude if there is nothing that can  
29  
30



1 be done about price cutting so why worry about it?

2 MR. MACLEOD: Do you feel that price  
3 cutting in the drug field is improper? Let me put  
4 it another way. Do you feel that to approach the  
5 public on the basis of better prices is improper?  
6

7 MR. PEPPER: No. I think that has  
8 been standard for many, many years, one of the stan-  
9 dard business-getters.

10 MR. MACLEOD: Is that applicable to  
11 the drug trade?

12 MR. PEPPER: Are you speaking of  
13 prescriptions now?

14 MR. MACLEOD: Prescriptions.

15 MR. PEPPER: I don't think it is.  
16 This is just a personal opinion. It suggests that  
17 perhaps there may not be proper care given; that  
18 some place there has to be a corner cut to reduce  
19 the price considerably.

20 MR. MACLEOD: Would you consider it  
21 unethical for a druggist to advertise he would  
22 allow 25 cents off the cost of prescriptions if a  
23 person would bring the prescription in and accept  
24 delivery at the store?  
25

26 MR. PEPPER: There is nothing that I  
27 know of that says it is unethical in our Act at all  
28 or in our bylaws.

29 MR. MACLEOD: Would you, as a druggist,  
30 consider it unethical?



1 MR. PEPPER: Yes.

2 MR. MACLEOD: For what reason?

3 MR. PEPPER: Well, I think it implies  
4 that they can produce this medicine more cheaply  
5 than someone else and perhaps implies also that some  
6 corners are cut to do so.

7  
8 MR. MACLEOD: In certain other provinces,  
9 at least, this form of advertising has appeared. A  
10 druggist will advertise that he will fill a prescrip-  
11 tion at the cost of the ingredients at wholesale plus  
12 a fee of \$1.00. Would you consider that unethical?

13 MR. PEPPER: I don't think so, though  
14 I think he would be very foolish to name that parti-  
15 cular fee.

16 You have touched on a pricing method  
17 that has been advocated by some of our economic  
18 experts that has some very interesting suggestions.  
19 I think that he would be cutting his own price because  
20 at cost plus a dollar he would not find it very profi-  
21 table.

22 MR. MACLEOD: You would regard it as  
23 not being unethical?

24 MR. PEPPER: Oh, I don't really know.  
25 It is very close to the borderline. It is very close  
26 to price cutting because at that fee, I don't think  
27 he could make any money.

28  
29 THE CHAIRMAN: I am not quite sure  
30 whether Mr. Pepper got your question fully about the



1 matter of a 25-cent reduction if the person comes  
2 to the drugstore and gets a prescription. I think  
3 what Mr. MacLeod had in mind was a difference in  
4 price when a person comes in and gets the prescrip-  
5 tion in the store as compared to the case where the  
6 product is delivered and you have to pay somebody  
7 for delivering it.

8 MR. PEPPER: I see. In other words,  
9 if you come and get the prescription, I will give  
10 you 25 cents less?  
11

12 THE CHAIRMAN: Yes.

13 MR. PEPPER: I don't see anything the  
14 matter with it. It costs more than that to deliver  
15 it.

16 THE CHAIRMAN: I thought you did not  
17 understand that. There would be a difference in the  
18 cost of operation.

19 MR. PEPPER: Yes, definitely.

20 Mr. Jansen just remarked that cost plus  
21 a dollar may be in the nature of loss-leader because  
22 in this area anyway we think it costs over a dollar  
23 to handle each prescription that comes in.

24 MR. MACLEOD: Moving away from pres-  
25 cription drugs, what about the other drug products?  
26 Do you, as a druggist, feel there should be price  
27 competition on those; patent medicines and the like?

28 MR. PEPPER: Well, there is. We have  
29 learned to live with it. We do not do anything about  
30



1 it.

2 MR. MACLEOD: If somebody puts on a  
3 special say on Carter's Little Liver Pills or Dodds  
4 Kidney Pills or something like that, that is common  
5 in this area?  
6

7 MR. PEPPER: Quite common.

8 MR. MACLEOD: There are certain drugs  
9 that are difficult to define. They are frequently  
10 used on prescription but they are not legally  
11 required to be prescribed.

12 MR. PEPPER: What we usually to as  
13 proprietaries.

14 MR. MACLEOD: Yes or sometimes "over  
15 the count ethicals".

16 MR. PEPPER: Yes.

17 MR. MACLEOD: What about that class of  
18 product? Is there price cutting on those, in your  
19 experience?

20 MR. PEPPER: Very little because so  
21 little is known about them. They are not advertised  
22 to the public usually and there doesn't seem to be  
23 much point in advertising a cut price on a commodity  
24 that is not known to the public.

25 MR. MACLEOD: You would be allowed to  
26 advertise the price of such a product, would you not?

27 MR. PEPPER: Yes.

28 MR. MACLEOD: Although you could not  
29 advertise it as being a remedy for stomach ulcers or  
30





1 something like that?

2 MR. PEPPER: There is nothing that  
3 would stop you advertising the price.

4 MR. MACLEOD: In your work do you use  
5 the price published by the Canadian Pharmaceutical  
6 Association?

7 MR. PEPPER: Yes. This is one of the  
8 most convenient references we have ever had.

9 MR. MACLEOD: In your practice do you  
10 follow the suggested retail price as shown in this  
11 book?

12 MR. PEPPER: No. This is a very, very  
13 good guide but - put it this way - speaking personally  
14 in my practice I do follow it but there are many  
15 items not on this list to follow. You have to go  
16 down to a price level set by somebody else.

17 THE CHAIRMAN: You mean by that you  
18 follow it except when you have to meet competition?

19 MR. PEPPER: Right.

20 MR. MACLEOD: Speaking of competition:  
21 does that come from other drugstores?

22 MR. PEPPER: Yes.

23 MR. MACLEOD: I suppose the articles  
24 that are sold in a general store would be very, very  
25 small in relation to --?

26 MR. PEPPER: No. The general stores  
27 sell a good many articles which are also sold by  
28 the drugstores. There is very definite competition  
29  
30



1 from that source as well.

2 MR. MACLEOD: Do you find the competi-  
3 tion more marked in the case of these articles than  
4 in the case of articles which are sold by drugstores  
5 only?

6 MR. PEPPER: No, I don't think so. It  
7 is not quite as noticeable. No, I don't think so.

8 MR. MACLEOD: Do you regard "pay and  
9 save drugstores" as discounters or price cutters?

10 MR. PEPPER: To a certain extent, yes.

11 MR. MACLEOD: On prescriptions?

12 MR. PEPPER: I don't know. I doubt it.  
13 I shouldn't - I won't say. I just don't know.

14 MR. MACLEOD: Your impression is in  
15 respect to other products.

16 MR. PEPPER: To other products. They  
17 very definitely advertise their products and their  
18 price.

19 MR. MACLEOD: How long has the "pay and  
20 save store" been operating in Regina?

21 MR. PEPPER: About two years.

22 MR. MACLEOD: Has it produced a compe-  
23 titive effect on the market?

24 MR. PEPPER: It has probably added a  
25 little more competition than previously existed but  
26 there was plenty before they came.

27 MR. MACLEOD: Is that the only store  
28 of that type in Regina?  
29  
30



1 MR. PEPPER: The only one that so adver-  
2 tises, yes but there is much competition from the  
3 other stores as well.

4 I think we all take our turn at putting  
5 on specials to attract trade.

6 MR. MACLEOD: Would you care to express  
7 an opinion on this: your brief somewhere says that  
8 there is not enough prescription business to keep  
9 the average store going.

10 MR. PEPPER: Yes.

11 MR. MACLEOD: Isn't this an old-fashioned  
12 way of handling the whole affair; to have the pres-  
13 cription business split up in small little bits and  
14 pieces here and there which make it necessary economi-  
15 cally for each small unit to charge very high prices  
16 in order to exist.

17 MR. PEPPER: I don't think it has any  
18 effect on the prices of prescriptions because the  
19 rest of the store carries the overhead of the business  
20 and you must look at it in this area anyway, in  
21 Saskatchewan - I think there area - I counted 140  
22 stores in 20 locations and the other 160 locations  
23 are in rural areas. There is one store in the town.  
24 One druggist in the store.

25 If you had to rely on the prescriptions  
26 only to keep him in business, he wouldn't be there.  
27 He must have other items if these areas are to get  
28 pharmaceutical services.  
29  
30



1 In the cities you could certainly  
2 question that. Perhaps there should be less.

3 This is the type of business that most  
4 people are used to. They seem to like it. I am  
5 speaking of the pharmacy. I wouldn't be surprised  
6 but what the retail pharmacist, who is established  
7 in business also likes it.  
8

9 THE CHAIRMAN: Have you studied the  
10 situation, Mr. Pepper, in regard to where there is  
11 a marked difference between the pricing in Saskat-  
12 chewan, which I think is very largely rural ---

13 MR. PEPPER: Yes.

14 THE CHAIRMAN: Than most other provinces ---

15 MR. PEPPER: Yes.

16 THE CHAIRMAN: And the other provinces.  
17 What I am getting at is you have two or three or four  
18 cities, none of them would be described as very large  
19 cities ---

20 MR. PEPPER: No.

21 THE CHAIRMAN: You have a fairly large  
22 number of small centres. Have you made any study to  
23 see whether the position, about which you are speaking,  
24 in Saskatchewan, differs substantially from that in  
25 other provinces?  
26

27 MR. PEPPER: We have made no study.

28 Are you aware of any particular diffe-  
29 rence, Mr. Ramsay?

30 MR. RAMSAY: I think perhaps in the



1 city store, the average city store has a larger  
2 percentage of prescriptions than the average rural  
3 store.

4 In the survey that Professor Sommers  
5 has prepared, the average is 28%. I find in my  
6 store that the average prescriptions comprise 20%  
7 of my store, which is considerably lower than 28%,  
8 which is the Provincial average.

9 THE CHAIRMAN: You are in Carlyle?

10 MR. RAMSAY: I am in Carlyle, a town  
11 of about 1,000 people.

12 THE CHAIRMAN: And is yours the only  
13 store?

14 MR. RAMSAY: The only store. I have  
15 one in the towns on each side of me.

16 THE CHAIRMAN: You do not draw from a  
17 very big area?

18 MR. RAMSAY: We do happen to have a  
19 summer resort too.

20 THE CHAIRMAN: Yes, I know.

21 MR. RAMSAY: That helps some.

22 While I am speaking I would just like  
23 to refer back to the situation where reference was  
24 made to the Pay and Save.

25 Several customers have told me that  
26 they have gone in to purchase certain items in Pay  
27 and Save and they have been told by the clerk that  
28 that price was not on at the present time.  
29  
30





1                                They have heard the clerk be told by  
2  
3       one of the higher-ups in the organization that for  
4  
5       country people those special prices apply at all  
6  
7       times but they do not in the city.

8                                That is just hearsay. I have been  
9  
10       told that by more than one of my customers.

11                               THE CHAIRMAN: Is that because this is  
12  
13       an agricultural province primarily?  
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/dpw

1 MR. MACLEOD: Perhaps we can't take  
2 this any further. According to your brief, there  
3 are 310 retail pharmacists in Saskatchewan and  
4 apparently only six of those are able to operate on  
5 prescriptions only.

6 MR. PEPPER: I think the revised figure  
7 was seven.

8 MR. MACLEOD: So you have 303 outlets  
9 where the sale of prescriptions is necessarily tied  
10 to the sale of cigarettes and patent medicines and  
11 perfume and what have you. That seems to be a surpri-  
12 sing situation where a practising pharmacy, which  
13 is extremely important to the health of the public,  
14 should be so operated, and when you consider addi-  
15 tional factors that other types of outlets are prohi-  
16 bited by law to engage in this type of business.  
17 Don't you think that is an inefficient way in the  
18 business of getting prescription drugs from the  
19 drug manufacturers to the public?

20 MR. PEPPER: No, I don't agree with  
21 you at all. First of all, there would be some 600-  
22 odd rural areas which would be largely deprived of  
23 pharmaceutical services. You would have to have a  
24 large store every 150 miles.

25 MR. MACLEOD: Or provide small branches  
26 of large firms?

27 MR. PEPPER: Who is going to run them?

28 MR. MACLEOD: I was just suggesting  
29  
30



1 that would be a way to do it.

2 MR. PEPPER: I can't see that at all,  
3 because no large firm is going to establish a small  
4 branch office and pay a pharmacist to sit there.

5 MR. MACLEOD: I am not saying it  
6 should or shouldn't, but I am suggesting there may  
7 be a more efficient method of getting the prescrip-  
8 tions to the consumer.

9 MR. PEPPER: I think this is the most  
10 efficient we can find.

11 MR. MACLEOD: This is what we want,  
12 your views on that situation.

13 Now, ignoring for the moment the pharma-  
14 cist's time, how does the profit on drugs sold by  
15 prescription, that is the profit on the actual ingre-  
16 dients themselves, compare with the profit on other  
17 items sold in drugstores?

18 MR. PEPPER: It is about the same. 40%  
19 is the average profit. Whether it be a bottle of  
20 cough medicine on the shelf ready to be handed out or  
21 a prescription, it is 40%, provided it is bought from  
22 the manufacturer and not through a wholesaler.

23 MR. MACLEOD: Do you get 40% on Bayer's  
24 aspirin?

25 MR. PEPPER: Yes.

26 MR. MACLEOD: So 40% --

27 MR. PEPPER: And in small quantities,  
28 30%.



1 MR. MACLEOD: I notice you suggested in  
2 your brief it would make about 10% difference, the  
3 pharmacist would receive 10% smaller profit if he  
4 purchased from a wholesaler than if he purchased  
5 direct from a manufacturer.

6 MR. PEPPER: That is correct.

7 MR. MACLEOD: And if he was able to  
8 purchase in very large quantities it may increase  
9 his profit by 2% or 3%?

10 MR. PEPPER: Yes.

11 THE CHAIRMAN: When you referred to  
12 the 40% you did specifically refer to certain types  
13 of drugs. I thought the question was related to  
14 other types sold in drugstores.

15 MR. PEPPER: Some have 33.1/3, for  
16 instance, some cosmetics 40%.

17 THE CHAIRMAN: Or some perfumes?

18 MR. PEPPER: Yes.

19 THE CHAIRMAN: I thought there was  
20 some variation.

21 MR. PEPPER: Yes, there is. As a  
22 matter of fact, the margin of prescription drugs  
23 from manufacturers runs through 22½% to 44%.

24 THE CHAIRMAN: For the same product?

25 MR. PEPPER: No, each manufacturer is  
26 a little different, and one wholesaler may be 22½%,  
27 another might be 40%. There is no uniformity there.

28 THE CHAIRMAN: In that type of situation  
29  
30



1 you would buy through a manufacturer?

2 MR. PEPPER: Yes, in some cases you  
3 have to buy through the wholesaler, and, in fact, the  
4 wholesaler provides a very valuable service.

5 MR. RAMSAY: Especially in a rural  
6 area where the prescription volume is not large.

7 MR. MACLEOD: Are you familiar with the  
8 Canadian Pharmaceutical Journal?

9 MR. PEPPER: Yes.

10 MR. MACLEOD: In February, 1961, there  
11 appeared a rather provocative article: "Do Retail  
12 Pharmacists Deserve Professional Status". I wonder  
13 if any of you gentlemen have seen this article and  
14 the comments and if you would care to express any  
15 opinions which you feel in connection with it.

16 MR. PEPPER: I don't recall enough.  
17 I recall at the time I was very interested in it.  
18 I think one man described it as a shock treatment,  
19 and those things are always good.

20 MR. MACLEOD: There is rather a sugges-  
21 tion in that that if the retail pharmacist requires  
22 any training at all it could be handled in six months  
23 and that the present expensive training for pharmacists  
24 is not necessary because, in essence, he is simply a  
25 merchant, passing over goods already prepared. I  
26 just pass that on because there may be some comments  
27 you may have.

28 MR. PEPPER: This is a statement that  
29  
30





1 is made many times, and it may appear to be that we  
2 are just picking up an article and putting it in a  
3 box and that is all there is to it. But you have to  
4 consider what that article is and what it is for.  
5 In fact, a four-year course in itself is not enough,  
6 it requires experience as well.

7  
8 PROF. SOMMERS: I was wondering if you  
9 were making a statement or asking a question. I  
10 didn't get the point of your comment.

11 MR. MACLEOD: I was just drawing this  
12 article to the attention of the gentlemen here who  
13 are associated with the trade and asking them if  
14 they have any comment on it. I am essentially  
15 raising the position of the pharmacist, whether the  
16 retail pharmacist serves any useful purpose at all  
17 or whether he is just a merchant.

18 MR. WHITE: On this article, Mr. Chair-  
19 man, I have forgotten some of the details of it,  
20 but these men are commenting on another article by  
21 a teaching pharmacist in the United States and we  
22 have the viewpoint of three men, the Dean of Pharmacy  
23 in Alberta, a Saskatchewan pharmacist, Keith Larkin  
24 in Halifax, and Mr. Roger LaRose, who is associated  
25 with a pharmacy in Montreal, and Bruce Moyer in  
26 Winnipeg. This first man wrote his own article, and  
27 actually I think we are all taking a hard look at  
28 pharmacies right now, and these five gentlemen from  
29 across Canada - it all boils down and my opinion of  
30



1 their reply to this article - I think Mr. Quinn  
2 mentioned it was the people who come in to speak to  
3 their pharmacist. There are a lot of economics to  
4 this business of pharmacy, but we are dealing with  
5 people and it is our professional attitude not only  
6 to our profession but to the people, and the people  
7 we usually deal with are usually not well people,  
8 they are sick people. You can't look at it with a  
9 straight commercial attitude. There are things in  
10 pharmacy which really don't make sense in the true  
11 sense of the words. It is your relations with the  
12 people you serve, and a lot of our people, customers,  
13 are sick or have ailments and they come to pharmacies  
14 for remedies and for comfort, really.

15  
16 PROF. SOMMERS: You realise, of course,  
17 I am engaged in pharmacy, although somewhat different,  
18 in the hospital, and I do employ other pharmacists  
19 and I see them working and I can certainly tell you  
20 from my experience and the type of work they do that  
21 the type of training that they have is absolutely  
22 essential. To think that anyone could learn the  
23 fundamentals that go behind the work that these people  
24 do in six months is just not so.

25  
26 Something happened in Regina some time  
27 ago. One of the things that a lot of people miss -  
28 they say: "Now, look, you take a drug. All you do is  
29 take it from one bottle and put it in another". In  
30 some cases that is done, but the essential thing is



1 to know what you put from one bottle to another.  
2 In Regina a drug was taken from one bottle and it  
3 was put into another and it was labelled distilled  
4 water when, in fact, it was carbolic acid.

5 MR. MACLEOD: I don't think your  
6 example is very apt, because people are handling  
7 these items who are not pharmacists.

8 PROF. SOMMERS: Professional judgment  
9 should have been exercised in that case. This is  
10 a case where a properly trained professional person  
11 was not responsible for what was done.

12 MR. MACLEOD: But the products you  
13 are speaking of are not prescription products.

14 PROF. SOMMERS: These products are  
15 very often handled by a pharmacist and as such  
16 professional responsibility must be taken for them.

17 Take a hypothetical case. Let's say  
18 that tablets of a narcotic are mislabelled, or a  
19 barbiturate. Are these things which you would like  
20 to have handled by a person with six months' training?  
21 May I ask a question?

22 MR. MACLEOD: Well, to sum up, you  
23 say a person with six months' training would not be  
24 competent to handle prescription items?

25 PROF. SOMMERS: No, I think it requires  
26 a person with four years' training to handle compe-  
27 tently the prescription items which we handle.

28 There is another side of the  
29  
30



1 professional aspect of the pharmacist. We have in  
2 the hospital a poison control centre. This may  
3 happen in the retail pharmacy just as in a hospital,  
4 and I would say that 75% of the calls that come into  
5 hospitals are relayed to the pharmacist and he is  
6 asked to express a professional opinion on this  
7 particular information. This professional service  
8 does not involve a charge.  
9

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1                                   Let me give you another example. A  
2 patient is brought into hospital, or may come home  
3 from a hospital, and was given a prescription by a  
4 physician in the hospital. When he comes in his own  
5 physician would like to know what drug he is now on,  
6 so what happens is that the physician comes to you  
7 with three or four different capsules and says we  
8 want to digitilize this man, will you tell us what  
9 he has been on. If the patient has been already  
10 digitilized and you try to do it all over again, you  
11 are going to find yourself in grave difficulty. He  
12 is called upon to express a professional opinion and  
13 says in my opinion this is how I identify this. I  
14 am not saying he is 100% right. Who is in profes-  
15 sional judgment 100% right?

16  
17                               THE CHAIRMAN: I suppose sometimes,  
18 Professor, the amount of professional judgment  
19 which can be exercised in a case is not very great.  
20 I am talking about the case where you merely take  
21 the label off a bottle and put another one on and  
22 don't look in the bottle at all, and are relying on  
23 the manufacturer and your knowledge of the manufac-  
24 turer, and what you can see through the glass in the  
25 bottle?

26  
27                               PROF. SOMMERS: I agree. I would say  
28 in this case that although your exercise of  
29 professional judgment is not great, this does not  
30 reduce your assumption of professional responsibility.





1 THE CHAIRMAN: If the manufacturer  
2 has been guilty of a slip, you would have no means  
3 of checking it?  
4

5 PROF. SOMMERS: You are quite right.  
6 I agree with you heartily.

7 MR. MACLEOD: Do you find that massive  
8 promotional campaigns by the manufacturers for the  
9 use of a new drug or particular drug, addressed to  
10 the doctors, has an effect on your business?

11 MR. PEPPER: Generally speaking, no.  
12 We can feel the effect of a campaign ultimately,  
13 but it seems to me that the doctors do not  
14 immediately pick up the information given to them  
15 in one of these massive campaigns. We do not see  
16 this literature. All we see is the product informa-  
17 tion which comes to us, but I cannot say that I have  
18 ever seen or felt any great surge in any particular  
19 drug as a result of those massive campaigns.

20 MR. WHITE: Our pharmacy is on the  
21 third floor of a building containing quite a few  
22 doctors, and our business is pretty well strictly  
23 prescriptions. Are you speaking only of mail  
24 campaigns?  
25

26 MR. MACLEOD: Well, take a drug like  
27 brocsil, or syncillin, that is a new form of peni-  
28 cillin. Presumably some promotion was done in  
29 connection with those. Would you find that reflected  
30 in your sales of that drug?



1 MR. WHITE: All I would say, yes, it  
2 depends sometimes on the type of promotion, whether  
3 it be direct contact by a detail man or literature.  
4 There is quite an effect by each one of those on  
5 prescriptions, but we definitely do find that  
6 things are prescribed after having been --

7 MR. MACLEOD: Perhaps you would amplify  
8 on the point you mentioned that you found a difference  
9 in promotion by detail men and direct mail?  
10

11 MR. WHITE: We cannot tell what litera-  
12 ture they get, because we don't necessarily get the  
13 same literature as the medical man does. You cannot  
14 tell how much literature they get, but we do know  
15 when the medical representatives are in town or in  
16 our building, and certainly that is their job and  
17 they do increase the use of their prescription pro-  
18 ducts.

19 MR. MACLEOD: That is after detail men  
20 come around for a particular company and pushing a  
21 particular product you will find increased sales of  
22 that product?

23 MR. WHITE: It depends what the product  
24 is of course, because the medical man may not have  
25 occasion to use it. You may not have a call for it  
26 for weeks.

27 MR. MACLEOD: How about some of the  
28 penicillins I named to you?  
29

30 MR. WHITE: Brocsil, we haven't used a



1 tablet of that particular one, but I think maybe  
2 their representatives, something happened along the  
3 line, but that particular one in that particular  
4 case we haven't used a tablet, but that is not to  
5 say that for the regular run of detail men --

6  
7 PROF. SOMMERS: This is particularly  
8 a penicillin product which is priced in the wide  
9 spectrum antibiotic range and is completely over-  
10 priced, and for this reason has not been prescribed.

11 MR. MACLEOD: You think price is a  
12 factor in doctors not prescribing?

13 PROF. SOMMERS: Yes definitely, a  
14 major factor in this particular drug.

15 THE CHAIRMAN: Mr. White, is it your  
16 opinion that the detail men are fairly effective in  
17 their work of spreading the gospel about new drugs?

18 PROF. SOMMERS: It is very difficult  
19 to answer in generalities regarding manufacturers'  
20 representatives, because these men are individuals,  
21 and it depends first of all on what he has to talk  
22 about, if it is something for which there is a  
23 requirement then I think he will get some attention.

24  
25 Secondly, if he is able to speak  
26 about his product intelligently, to discuss not only  
27 his own product, but the whole field, the whole  
28 range of therapy with which his product deals, in  
29 such cases he will generally be more successful,  
30 because perhaps he can explain the situation a little



1 better and is much more than a salesman. He can be  
2 of some help. On the other hand, some cannot because  
3 of their lack of knowledge.

4 THE CHAIRMAN: I am asking because of  
5 something Mr. White said, whether in his experience  
6 he felt that they are generally fairly effective in  
7 their work?

8 PROF. SOMMERS: I would say they are.

9 MR. WHITE: I would say if they didn't  
10 have any detail men they wouldn't last for long.

11 MR. PEPPER: When a particular product  
12 comes along there is a great movement. Two years  
13 ago the chlorothiazides came along and took hold.  
14 It totally replaced many other diuretics, and this  
15 is where the effect is generally noticeable.

16 THE CHAIRMAN: One point in your brief  
17 I would like to ask about, medical services repre-  
18 sentatives of manufacturing firms. Those are the  
19 detail men are they?

20 MR. PEPPER: Yes.

21 THE CHAIRMAN: And you say about 40  
22 are pharmacists?

23 MR. PEPPER: Yes.

24 THE CHAIRMAN: Do you have any basis  
25 for giving an opinion as to what percentage of the  
26 detail men are qualified pharmacists in this Pro-  
27 vince?

28 MR. PEPPER: Oh, most of them I think.



1 There might be a dozen more who are not pharmacists,  
2 who have general chemical training.

3 PROF. SOMMERS: At one time they were  
4 practically all pharmacists, but the trend is  
5 swinging at the present time to the non-pharmacist,  
6 I think simply because of the fact that there are  
7 not enough pharmacists to do this job.

8 THE CHAIRMAN: Is it your experience  
9 that those who are qualified pharmacists can do a  
10 much better job than those who are not?

11 PROF. SOMMERS: Generally speaking,  
12 yes, but depending on the background of the indivi-  
13 dual. If he is a man who is trained in the basic  
14 sciences and can read scientific literature intelli-  
15 gently, he need not necessarily be a pharmacist to  
16 be a good detail man.

17 THE CHAIRMAN: He may have had some  
18 pre-medical training.

19 PROF. SOMMERS: Absolutely sir. I  
20 remember one lad trained in agricultural chemistry.

21 MR. MACLEOD: I think you said that  
22 the present normal rate of discount to the retail  
23 druggist is 40%?

24 MR. PEPPER: Yes.

25 MR. MACLEOD: Was it formerly 35%?

26 MR. PEPPER: Quite some years back,  
27 33.1/3.

28 MR. MACLEOD: That change was  
29  
30





1 accomplished, was it not, by pressure by the pharma-  
2 cists to get a better discount?

3 MR. PEPPER: I couldn't say pressure.  
4 I suppose complaints constitute pressure, yes.

5 MR. MACLEOD: Are new products a  
6 problem to you? Do you find it difficult to keep  
7 up with the new products coming out, involving  
8 stocking problems and so forth?

9 MR. PEPPER: There are stocking pro-  
10 blems, but we have arrangements with most of the  
11 better-known manufacturers that they will automati-  
12 cally ship us a very small quantity. If we do not  
13 immediately index and file the information on this  
14 new product, then we may be lost. We take each one  
15 as it comes and learn something about it and have  
16 the informational material readily available. There  
17 is no problem at all.

18 MR. MACLEOD: How many new products  
19 would you have to deal with in an average month?

20 MR. PEPPER: It is easy to start an  
21 argument amongst us here. I would say six or eight.

22 MR. MACLEOD: Well, I suppose that  
23 could be gathered by going through the Canadian  
24 Pharmaceutical Journal for a year and looking at  
25 the monograms which I believe are prepared by Dean  
26 Hughes of Toronto.

27 MR. PEPPER: I should have confined my  
28 answer to six or eight that I stock. Probably, as  
29  
30



1 you say, there may be a dozen or so in there, and  
2 many of the monograms in there are actually of old  
3 products which were not previously listed.

4 MR. MACLEOD: And some of them of  
5 course would be simply new dosage forms of a product  
6 with which you were already familiar, but at any  
7 rate your estimate is six or eight?

8 MR. PEPPER: Yes, that we handle.

9 MR. MACLEOD: Do you have any problem  
10 in drugs becoming obsolete, or physicians no longer  
11 prescribing?

12 MR. PEPPER: This is a standard part  
13 of the business. Incidentally, most manufacturers  
14 will accept returns of unopened packages, but not  
15 broken packages, and it is a very clever stock-keeper  
16 I think who can judge the amount of usage and to be  
17 able to buy the larger quantities when the drug is  
18 in popular use, and work his stock down to almost  
19 nil when it is replaced. Usually we get stuck with  
20 something or other.

21 MR. MACLEOD: Does the continually  
22 bringing on the market of new products affect you  
23 in any other way that I haven't touched on?

24 MR. PEPPER: Just by increasing the  
25 amount of stock we are required to carry.

26 MR. MACLEOD: Are older products  
27 going out of fashion?

28 MR. PEPPER: They are generally, but  
29  
30



1 there is always someone who has had very, very good  
2 results with product so-and-so, and continues to  
3 use it.

4 MR. MACLEOD: It has been suggested,  
5 and there is a quotation in the book of material to  
6 this effect, that even where the principal drug, for  
7 example take terramycin, or some of those, may later  
8 lose its popularity, that combinations of that drug  
9 in ointments, eye-drops, lotions and the like may  
10 continue to be popular?

11 MR. PEPPER: This is quite so.

12 MR. WHITE: I would think so, or in  
13 some of its other forms.

14 MR. MACLEOD: Yes, in some other  
15 combination forms?

16 MR. PEPPER: I have not had a call for  
17 terramycin capsules for a long time, but I did the  
18 other day have terramycin ophthalmine.

19 MR. MACLEOD: It is rather odd that  
20 you should say that, because the druggist I put the  
21 same question to in Winnipeg said it was not that  
22 way, that the subsidiary products die with the main  
23 product.

24 MR. PEPPER: Not necessarily.

25 MR. MACLEOD: No, our general infor-  
26 mation is largely to the effect of what you have  
27 stated. I think you have already said in some of  
28 your general remarks that the wholesaler performs a  
29  
30



1 very important function. Do you think he might  
2 perform too great a function, in keeping many drug-  
3 stores in business who couldn't operate on their own?

4 MR. PEPPER: No, I don't think so. If  
5 it did serve to close down some small drugstore in a  
6 small community it would do a good service.

7 MR. WHITE: He couldn't get his stock,  
8 and the wholesaler is of great importance to it.  
9 They have it when you are out of it. That is impor-  
10 tant.

11 MR. MACLEOD: Are you, as a retail  
12 druggist, ever called on to supply a hospital?

13 MR. PEPPER: Very rarely, and in fact  
14 in Regina I am not. Perhaps you should ask Mr.  
15 Ramsay on that.

16 MR. RAMSAY: Very occasionally. We  
17 haven't a hospital in our own town, but we have one  
18 in an adjacent area, and possibly once or twice a  
19 year we might be called upon to supply a hospital.  
20 Certainly not often.  
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MR. PEPPER: May I tell you Mr.

Chairman in one or two or perhaps three areas in Saskatchewan the retail pharmacist actually does some of the dispensing for the hospital but he does not sell to them. He really dispenses the drugs which they buy themselves.

I think in a smaller community the hospital finds that the retailers will be asked to supply some items.

MR. MACLEOD: But quite naturally the hospital buys from the wholesaler or the manufacturer.

MR. PEPPER: I don't think hospitals even buy from the wholesaler because the wholesale price to the hospital is approximately the same as he would charge to the retailer; whereas the price to the hospital from the manufacturer is much lower than the price to the retailer.

MR. MACLEOD: So that they go to the manufacturer, whenever possible?

MR. PEPPER: Whenever possible, yes.

MR. MACLEOD: Do you find that it is the practice of some of the so-called large ethical drug manufacturers to restrict the sale of their products to drugstores?

MR. PEPPER: Well, they have no choice in most things. Just -- are you getting at what we would call counter items?





1 MR. MACLEOD: Counter items rather than  
2 dispensary items.

3 MR. PEPPER: I don't know. Is it the  
4 practice?

5 MR. WHITE: There is the odd one that  
6 I can think of offhand.

7 MR. MACLEOD: For instance - I am  
8 sorry.

9 MR. WHITE: They do come in frequently  
10 - I say they call on no one else but the pharmacist.

11 They may not have any other outlet for  
12 their products even though it could be sold. I am  
13 thinking of hay fever remedy. You will not find it  
14 anywhere but a pharmacist.

15 MR. JANSEN: Frosst is one of those.

16 MR. MACLEOD: Frosst ASA tablets.

17 MR. WHITE: I was not thinking of the  
18 Frosst Company. I am not just certain about them.

19 MR. PEPPER: Generally speaking,  
20 Frosst usually call only on the drugstores.

21 MR. MACLEOD: I believe Metrecal is  
22 only sold through drugstores.

23 MR. PEPPER: That is right.

24 MR. MACLEOD: That is certainly  
25 company policy.

26 MR. PEPPER: No. That is - I think  
27 it varies from Province to Province, depending on  
28 the Pharmacy Act but the Food & Drug people ruled  
29  
30



1 that Metrecal would be under the Drug Regulations.

2 That was Dr. Morrell's statement.

3 MR. MACLEOD: It is a fact, of course,  
4 that certain other products apparently comparable  
5 are being sold from non-drug outlets, is it not?

6 MR. PEPPER: I see what you are  
7 getting at. Yes, in the Province where these may  
8 be sold in non-drug outlets, Metrecal has been  
9 retained in drugstores. Yes, I see your point.  
10 That is company policy.

11 MR. MACLEOD: The general question I  
12 asked first was: do the large ethical drug firms as  
13 a matter of practice restrict the sale of all of  
14 their products to drugstores?

15 MR. PEPPER: I can think of three or  
16 four or six who have dealings only with drugstores.  
17 I am not sure that they restrict their sales to  
18 drugstores. You mentioned Frosst. I think they do.

19 MR. MACLEOD: Parke-Davis?

20 MR. PEPPER: Parke-Davis - I don't  
21 really know.

22 MR. MACLEOD: Well, perhaps we cannot  
23 take that any further.

24 MR. WHITE: In cases like that you  
25 can take the Hudson's Bay in Saskatoon where they  
26 have no pharmacy, no actual pharmacy in their store  
27 but they, I think, do handle Parke-Davis or Frosst  
28 products. Perhaps Mr. Jansen knows.  
29  
30



1 MR. JANSEN: No, not Frosst.

2 MR. WHITE: Well then that corrects  
3 me. I haven't been in the new store since they  
4 built it. I thought possibly they were. Mr. Jansen,  
5 our inspector, assured us they do not.

6 MR. MACLEOD: Thank you. Those are  
7 all the points I wish to touch on, Mr. Chairman.

8 MR. WHITELEY: On page 2 of the state-  
9 ment the sentence appears: "The enrolment of phar-  
10 macy students has up to this point, barely met the  
11 demand".

12  
13 When we were in Winnipeg we were  
14 informed that the limitation on the number of stu-  
15 dents was due to the limitation of facilities for  
16 teaching; but the feeling of this sentence here is  
17 that it is due to reluctance of people to enter  
18 into training for pharmacy.

19 PROF. SOMMERS: That is right. I  
20 don't think there is - not at least at the present  
21 time any limitation on the number of students. I  
22 think it is a reluctance on the part -- Inciden-  
23 tally we had a fair number but most of them seemed  
24 to hit for greener fields. That could be part of  
25 the problem.

26  
27 MR. WHITELEY: You could take this  
28 larger enrolment, as far as the facilities for  
29 teaching are concerned.

30 PROF. SOMMERS: We are just reaching



1 our limit in facilities under which we are working.  
2 We feel that we can accommodate a maximum class of  
3 approximately 75 students in each of the four years.  
4 We are now enrolling approximately 60. We have been  
5 assured that adequate facilities will be provided in  
6 the near future. Therefore the teaching accommoda-  
7 tion is not a factor at the present time.  
8

9 MR. WHITELEY: Has the enrolment been  
10 going up or down?

11 PROF. SOMMERS: This varies, sir, for  
12 reasons of which we are not aware.

13 The last three years there has been an  
14 increase in enrolment. There was a tremendous  
15 increase in enrolment after the war. I think this  
16 was common in all faculties. After that there was  
17 a decrease.

18 In the last two years there has been  
19 a slight increase, not comparable to some of the  
20 increases in other faculties such as engineering  
21 where there has been a tremendous increase.

22 THE CHAIRMAN: How many have you been  
23 graduating? Can you give us the graduation figures  
24 for the last three or four years?

25 PROF. SOMMERS: This year, sir, there  
26 is 35. Last year there was approximately 27 and  
27 the year before that it would in the order of approxi-  
28 mately 35.  
29

30 THE CHAIRMAN: That is a fairly small



1 percentage actually graduate out of those who are  
2 students.  
3

4 PROF. SOMMERS: Yes but for the compa-  
5 rable year - in fact for 1960 we do expect this year  
6 we will have approximately 45 to 50 graduate.  
7 Another interesting point is that we find an increase  
8 in the proportion of women moving into our field.

9 THE CHAIRMAN: Have you any figures  
10 on the number, as you have suggested, who go to  
11 greener fields?

12 PROF. SOMMERS: I would say approxi-  
13 mately 50%, sir.

14 THE CHAIRMAN: Go outside the Province?

15 PROF. SOMMERS: Either go outside the  
16 Province or outside the sphere of retail pharmacy.

17 THE CHAIRMAN: Do you know how that  
18 compares, well or ill, with the results in other  
19 Provinces?

20 PROF. SOMMERS: Well, sir, we do not  
21 enrol many pharmacists from other Provinces. We  
22 send most of ours out. I do not think their  
23 experience would be similar to ours. They don't  
24 export such as we do.

25 THE CHAIRMAN: You are exporting  
26 brains and they are taking them?

27 PROF. SOMMERS: That is right, sir.

28 THE CHAIRMAN: Would any member of  
29 the group care to add anything to what we have  
30





1 already heard?

2  
3 MR. PEPPER: No, Mr. Chairman. We  
4 thank you very much.

5 THE CHAIRMAN: Thank you very much,  
6 gentlemen. We appreciate your coming here and  
7 devoting the whole morning pretty well to discus-  
8 sing these matters with us. Thank you.

9 Is there anybody present who wishes  
10 to make any representation to the Commission this  
11 morning? We do not expect that we will be sitting  
12 again in Regina so that if there is anybody, this  
13 is the time.

14 MRS. DAVIS: Mr. Chairman, may I say:  
15 I am the Provincial President of the C.A.C. in  
16 Saskatchewan.

17 I wonder if the Commission would be  
18 interested in some documented information that we  
19 have. We had a call from a gentleman yesterday.  
20 We are not presenting any brief as I believe our  
21 brief will be presented by our national office.

22 This man has some information in  
23 regard to drugs which he would like us to present  
24 here. Would you be interested in his information?

25  
26 THE CHAIRMAN: We are interested in  
27 any information that bears on any aspect of the  
28 inquiry.

29 MRS. DAVIS: We thought it was  
30 interesting because he had bought a drug elsewhere



1 and tried to get the same drug here. There was a  
2 difference. He had bought the medication for one  
3 shilling in Edinburgh and the same cost him \$30  
4 here.

5 THE CHAIRMAN: How much?

6 MRS. DAVIS: \$30.

7 THE CHAIRMAN: Instead of one shilling?

8 MRS. DAVIS: Instead of one shilling.

9 He is now purchasing the drug from his pharmacist  
10 in Edinburgh and having it sent out.

11 THE CHAIRMAN: I should think he would.

12 MRS. DAVIS: He gave us the informa-  
13 tion. He has it all written out and he would like  
14 to present it. Would you be interested in having  
15 it?

16 We haven't had an opportunity to  
17 investigate it or verify it.

18 THE CHAIRMAN: We have had some infor-  
19 mation, not showing as wide a variation in price  
20 as that, but we have had some information. We  
21 would be interested in it but to be really useful  
22 we would have to be sure it was the identically  
23 same drug and we would like to know the source of  
24 manufacture and that sort of thing.

25 MRS. DAVIS: That is the sort of  
26 information we would like to have before we would  
27 use it ourselves.

28 THE CHAIRMAN: We would like to have  
29



1 it but if he could give us these details it would  
2 be much more useful to us than it would by merely  
3 quoting the price difference.

4 Perhaps he could write or let you  
5 have the information and you could forward it to  
6 us in Ottawa or he could write to us in Ottawa,  
7 whichever is the more convenient way.

8 If there is nobody else, that will  
9 conclude the hearings this morning.

10 --- Whereupon the hearing adjourned until 10 a.m.  
11  
12 July 24th, 1961.









INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C. -- Chairman

A.S. WHITELEY, M.A.           Member of the  
Commission

PIERRE CARIGNAN, Q.C.       Member of the  
Commission

F.N. MACLEOD               Combines Officer,  
representing the Director of Investigation  
and Research

Proceedings of hearings commencing at  
10 a.m., Monday, July 24th, 1961, et  
seq, in the City of Edmonton, in the  
Province of Alberta.



1  
2 THE CHAIRMAN: Ladies and gentlemen,  
3 as you all know, this is a hearing before the  
4 Restrictive Trade Practices Commission in connection  
5 with an inquiry into the manufacture, distribution  
6 and sale of drugs.

7 We are here this morning to hear  
8 representations from organizations or individuals  
9 who believe they have something which may be of  
10 value to the Commission in ascertaining the relevant  
11 facts and the field is pretty broad in connection  
12 with the inquiry.

13 We would like to know first of all  
14 who are appearing and in what capacity and whom  
15 they represent. Then we can proceed to hear these  
16 various representations that they desire to make.

17  
18 Mr. MacLeod is appearing for the  
19 Commission.

20 DR. ROSS: Mr. Chairman, Dr. J.D.  
21 Ross, Minister of Health, appearing for the Alberta  
22 Government.

23 MR. FRAWLEY: Mr. Chairman, I am  
24 appearing as counsel for the Alberta Government.

25 MRS. MARLISS: Mr. Chairman, I am  
26 Mrs. B.P. Marliss, Alberta President of the Canadian  
27 Association of Consumers.

28 THE CHAIRMAN: Have we any others  
29 this morning besides the Government of Alberta and  
30 the Canadian Consumers' Association, Alberta Branch



1  
2 who wish to make representations this morning?

3 MR. MACLEOD: I had a 'phone call over  
4 the weekend from Mr. G.M. Grant-Smith, executive  
5 director of the Canadian Mental Health Association  
6 and I advised him that the Government of Alberta  
7 would probably be proceeding first. He will be  
8 here before 11 o'clock, he so informed me.

9 And then this afternoon Dr. F. Wein-  
10 stein, legislative chairman of the Alberta Podiatry  
11 Association, will be here at 2.15.

12 THE CHAIRMAN: If that is all that  
13 are appearing this morning, perhaps Dr. Ross, if  
14 you are going to make the presentation for the  
15 Alberta Government, you would come forward please.

16 MR. FRAWLEY: Dr. Ross, Mr. Chairman,  
17 is the Minister of Health for the Alberta Government  
18 and he has with him Dr. A. Summerville, Deputy  
19 Minister of Health and he also has with him Dr. F.B.  
20 Rodman, who is the assistant clinical professor of  
21 therapeutics at the University of Alberta and he has  
22 also with him Dr. J.B. Wood.

24 THE CHAIRMAN: All right, Dr. Ross.

25 MR. FRAWLEY: Do you wish Dr. Ross to  
26 assume the witness stand?

27 THE CHAIRMAN: I don't think it is  
28 necessary for him to come further forward. I  
29 think we will all be able to hear him and the  
30 people in the courtroom will be able to hear as



1  
2 well.

3 DR. ROSS: Mr. Chairman, members of  
4 the Commission: we are happy to have the opportunity  
5 of presenting the views of the Alberta Government  
6 to your Commission. As our counsel has indicated  
7 we have with us today Dr. Summerville, my deputy,  
8 and Dr. Rodman of the University Hospital and  
9 medical faculty and Dr. Wood, who have assisted in  
10 the preparation of this report.

11 I would like, sir, to read the brief  
12 through and then to make some comments on some of  
13 the areas and if the questions that are put to me,  
14 sir, cannot be answered by me, I hope that the people  
15 I have brought with me will assist you, sir, in  
16 getting the answers you would like.

17  
18 The purpose of this presentation to  
19 the Commission inquiring into the Manufacture,  
20 Distribution and Sale of Drugs is to define areas in  
21 which the impact of the cost of drug therapy upon  
22 the economy of Alberta, either to the individual  
23 citizen or to the Government, is a cause of concern.

24 "The health of the people" wrote  
25 Disraeli, "is really the foundation upon which all  
26 their happiness and all their powers as a state  
27 depend".

28 The present concept of social justice  
29 for all and its implementation by welfare and health  
30 agencies make the problem a vital one, both for



1  
2 those budgeting the money and those paying the taxes.

3           The trend to collectivism weakens the  
4 responsibility of the individual and increases the  
5 demands upon public funds. That these demands are  
6 increased by the high price of drugs is inevitable.

7           In Alberta, a Special Drug Committee  
8 of the Alberta Department of Public Health studying  
9 the feasibility of supplying steroids to those requi-  
10 ring long-term treatment for catastrophic disease  
11 found that, first the problem was one of economics,  
12 second that while the costs of the drugs were large,  
13 the cost of proper supervision of their administra-  
14 tion, once the agency assumed responsibility for  
15 their use, was prohibitive. (Two reports are  
16 attached as annexes to this presentation).

17           I will refer to those in more detail  
18 later.

19  
20           The present situation in regard to  
21 drugs is not confined to this segment of the whole  
22 field of manufacturing. In North America, there  
23 is more emphasis on marketing than on making.  
24 Making is defined as production and production  
25 implies an organization of design and materials on  
26 well thought out lines with an eye to consumer  
27 demand. Foreknowledge of the consumers' appetites,  
28 whims and desires plus the media to formulate them  
29 are the ruling factors in salesmanship and it is  
30 the salesman whose advice guides the production





1  
2 manager. Thus, the public gets what it wants, or  
3 what it is made to think it wants, even when what it  
4 wants may be against its own interest, both medi-  
5 cally and economically. Recognition that the pharma-  
6 ceutical industry has provided useful drugs and  
7 has contributed to scientific progress does not  
8 gainsay the fact that the huge volume of prescrip-  
9 tion drugs is produced and marketed in the same  
10 atmosphere that produces a rapid turnover in auto  
11 models and women's styles.

12                 Despite exceptions, premature and  
13 excessive promotion of drugs, inadequate investiga-  
14 tion and unnecessarily confusing duplication are  
15 common. New products are accepted more rapidly and  
16 become obsolete more rapidly. Generally today a new  
17 product either soars to popularity within the first  
18 few months after it is launched on the market or  
19 else the promotional program fails and the product  
20 is doomed to mediocrity. The sales people try to  
21 rush each new drug on to the market in the hope of  
22 a successful run. Such pressure works against deli-  
23 berate objective evaluation of the drug in clinical  
24 medicine. It produces emphasis on the maximum speed  
25 consistent only with reasonable assurance of rela-  
26 tively low toxicity, on a well chosen name for the  
27 product and a successful promotion campaign which  
28 may produce a best seller for a year or two. Should  
29 it appear eventually that a product is really a  
30



1  
2 valuable addition to the physician's armamentarium  
3 so much the better. Some of the responsibility for  
4 the failure of a large part of the clinical effec-  
5 tiveness of drugs to meet scientific standards must  
6 be ascribed to the urgency of the drug marketing  
7 methods.

8 THE CHAIRMAN: Dr. Ross, I wonder -  
9 there are a good many statements in that paragraph  
10 which are conclusions of fact - if you indicate in  
11 the brief any sources from which the facts are  
12 derived?

13 DR. ROSS: There are sources at the  
14 back, sir, references on page 6 of the brief which  
15 relate to some of these things.

16 THE CHAIRMAN: I saw that list but I  
17 was wondering whether these facts are derived from  
18 this particular source perhaps if they could be  
19 pinpointed a little bit, it would be helpful.

20 I rather think that when we hear from  
21 the drug companies, they may take exception to some  
22 of those statements.

23 DR. ROSS: Perhaps, sir, if I could  
24 call on some of my people later when I complete the  
25 brief, to answer some of these questions.

26 THE CHAIRMAN: Yes.

27 DR. ROSS: Under the Food and Drugs  
28 Act, warnings are placed on the label that the value  
29 of a given drug is unproven. While helping to  
30



1 control some of the worst abuses, these warnings are  
2 essentially negative measures.

3  
4 It does not seem practical or desirable  
5 to suggest that educational or governmental bodies  
6 be asked to perform clinical evaluation of all drugs  
7 produced. In the United States, from 1948 to 1959,  
8 there were 491 new clinical entities introduced.  
9 These 491 items, when handled by the trade, resulted  
10 in 1,085 duplicate products by other manufacturers,  
11 2,795 compounds of two or more active ingredients,  
12 and another 1,300 previously known drugs were re-  
13 introduced under new brand names. (1) (2) Numerous  
14 modifications of this type may be expected whenever  
15 the new drug becomes truly popular. Chlorothianzide  
16 introduced as Diuril in 1958 is an example. It was  
17 a commercial success to the point that in 1959 there  
18 were introduced four similar drugs with small changes  
19 in the molecule. Clinical experience with these and  
20 another three analogues have been published recently.  
21 (3) (4) (5) (6) (7) Some are more potent than the  
22 original but this means only a smaller (not neces-  
23 sarily cheaper) pill is required to produce the  
24 same desirable and undesirable effects. Increased  
25 potency is of no value without a difference in the  
26 "therapeutic ratio", i.e. the ratio of the dose pro-  
27 ducing desirable effects to the dose producing  
28 undesirable effects. Although there is no definite  
29 evidence of a differential in the therapeutic ratio  
30



1 or other features of the action of these congeners,  
2 either alone or in combination with other drugs,  
3 they are now under active promotion. Reports in  
4 the literature are nearly as confusing as the  
5 advertisements. (8) (9)

7 If there should be important advan-  
8 tages associated with the use of a particular one  
9 of these related chemicals, it is not at all cer-  
10 tain that such advantages could be recognized  
11 quickly. The task of evaluating scientifically the  
12 clinical usefulness and the drawbacks of a specific  
13 drug is usually a difficult and time-consuming  
14 undertaking. In the case of the thiazide prepara-  
15 tions, it is difficult to visualize any program to  
16 evaluate these drugs that will effect the atmos-  
17 phere of competitive promotion.

18 In Alberta, as a result of past  
19 experiences, where precipitate promotion interfered  
20 with objective clinical evaluation of new products,  
21 most clinician consultants refuse to undertake  
22 evaluation unless a clear undertaking is made that  
23 no promotion of a product is contemplated until  
24 adequate investigation to allow valid conclusions  
25 is completed. In the past, it has happened that  
26 active promotion of a drug with its attendant  
27 ballyhoo has been initiated in the United States  
28 within a few weeks after an investigation has been  
29 started at the University Hospital in Edmonton at  
30



1 the suggestion of the drug firms. This inevitably  
2 results in the investigator becoming an unwitting  
3 party to the promotion.  
4

5 Dr. Wilson, who is Professor of Medi-  
6 cine at our University Hospital, sir, has on occa-  
7 sions been asked to carry out clinical evaluations  
8 of drugs, only to find that before he can even get  
9 it under way to a proper evaluation and determina-  
10 tion of the efficacy of the drug, it was being  
11 actively promoted for sale to the public through  
12 the general medical profession.

13 THE CHAIRMAN: Yes, but that para-  
14 graph refers to it being advertised and promoted in  
15 the United States while investigation was going on  
16 in Canada.

17 DR. ROSS: Of course, sir, there is  
18 no boundary to the advertising that goes on in the  
19 drug trade.  
20

21 THE CHAIRMAN: I quite understand  
22 that. I was wondering whether you have clear evi-  
23 dence that it had not been previously studied and  
24 investigated in the United States.

25 DR. ROSS: I think, sir, that that  
26 question could be better answered by Dr. Rodman,  
27 who has taken an active part in the investigation  
28 of some of these drugs.

29 All the preceding is a statement of  
30 the conditions surrounding the drug industry today





1 in Canada. Coupled with this is the feeling that  
2 the current arguments over the purity of brand-  
3 named versus the generic-named products lacks  
4 validity is inescapable, especially when the leading  
5 manufacturers in Canada are importing from their  
6 parent companies in the United States or Europe.  
7 It must be pointed out that most large hospitals  
8 and institutions have been purchasing generically-  
9 labelled drugs for some time with no apparent  
10 decrease in their value to the patient, but most  
11 definitely a decrease in cost.  
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1 The urgency inherent in the prescri-  
2 bing of a drug and the emotional overlay resulting  
3 from illness both to the patient and to his rela-  
4 tives and friends make the provision of drugs a  
5 necessity even if the patient can't afford them.  
6 Whether the drug is essential to life or is merely  
7 palliative is irrelevant. Guilt complexes and the  
8 instincts of charity can be assuaged by the giving  
9 of a drug.

11 The Alberta Department of Public  
12 Health has recently become involved in the distri-  
13 bution of certain drugs because the family concerned  
14 had found the cost prohibitive. It was interesting  
15 to note that competitive bidding gave a lower price  
16 and that this price tended to go even lower as the  
17 competition became more keen. In comparing these  
18 prices with retail prices one should remember that  
19 these prices are sales tax exempt and are based on  
20 a large volume sale. A table showing these prices  
21 is attached.

23 There is very little manufacturing  
24 of primary drugs in Alberta and little or no  
25 research aimed at the production of new drugs.  
26 The distribution of drugs in Alberta follows the  
27 pattern which has developed across Canada. There-  
28 fore, it is the feeling of the Government of the  
29 Province of Alberta that not much can be added to  
30 the large volume of evidence which has been made



1 available to the Restrictive Trade Practices Commis-  
2 sion by the Director of Investigations and Research,  
3 Combines Investigation Act.  
4

5 However, this Province goes on record  
6 as believing:-

7 (1) That the price spread between the  
8 basic raw materials and the medicine as purchased by  
9 the patient is too great.

10 (2) That part of this increased cost  
11 is due to the elaborate attempts of various firms  
12 to develop and sell a close imitation of a success-  
13 ful drug.

14 (3) That part of this increased cost  
15 is due to large advertising campaigns which attempt  
16 to convince the medical profession and the public  
17 that a trade name drug is more effective than the  
18 equivalent generic-named drug.

19 Also, it is regrettable to note the  
20 success which drug firms have had in convincing  
21 the public that good health can be obtained by  
22 taking medicine.  
23

24 The Government of Alberta is con-  
25 vinced that the public is buying too many drugs  
26 and paying too high a price, both for necessary  
27 and for unnecessary drugs. It believes that the  
28 Director of Investigation and Research is in the  
29 best position to search out the needed informati  
30 and the Government hopes that he will be able to



1

2 provide helpful answers.

3 It is suggested that the Commission  
4 should look into:-

5 (1) the possibility of changes in  
6 federal and provincial legislation which would  
7 permit a pharmacist properly to dispense a generic  
8 equivalent even when a trade name drug is mentioned  
9 on the prescription unless the doctor specifically  
10 states that only the trade name drug is to be pro-  
11 vided.

12 I may say, sir, that this practice  
13 is being carried with the approval of the medical  
14 staffs of many of the hospitals in Alberta today  
15 to the benefit of the economy of the provision of  
16 drugs under our programmes.

17 THE CHAIRMAN: Do you mean by that  
18 that where a physician prescribes a drug by a trade  
19 name the pharmacist is considered at liberty to  
20 supply an identical drug that may be made by some-  
21 body else and it may have a different trade name or  
22 they can supply the same generic drug?

23 DR. ROSS: Yes, that is correct.  
24 That has been carried out with the consent of  
25 members of the medical staff rather than have a  
26 multiplicity of drugs on the medical shelves. So  
27 if the drug is the same, even though the trade name  
28 is not the same, it may be used.

29

30 THE CHAIRMAN: We have been told that



1 a pharmacist has no choice, even though it is on  
2 the prescription, that that is what he must supply.  
3 It is interesting to note the variation in Alberta.  
4

5 (2) The possibility of legislation  
6 that would prohibit the development of trade names;

7 (3) a proposal that the medical pro-  
8 fession or a disinterested body periodically publish  
9 a release to the practising physicians covering the  
10 advantages and disadvantages of new or modified  
11 drugs or combinations, but in terms uncoloured by  
12 sales promotion;

13 (4) a suggestion that the code of  
14 ethics of the medical and other prescribing profes-  
15 sions clearly defines that the doctor concerned has  
16 a definite responsibility to prescribe in such a  
17 way that his client is not forced to carry an unneces-  
18 sary load of expense.

19 I feel, sir, that having been a prac-  
20 tising physician for many years myself doctors have  
21 a responsibility to consider the economic status of  
22 their patient when they are considering the treatment  
23 that is in the best interest of the patient, and we  
24 feel that, although most medical men do feel this  
25 way, sir, I am sure that there are some who do not  
26 give as much thought to it perhaps as they should,  
27 which results in a considerable load of expense  
28 being carried by their patients which may otherwise  
29 be relieved.  
30





1 THE CHAIRMAN: It is sometimes said  
2 that doctors very commonly have no real knowledge  
3 of the price the patients may have to pay, and if  
4 that is the case it is rather difficult for them to  
5 distinguish.

6 DR. ROSS: That is correct.

7 MR. FRAWLEY: Dr. Ross, before you  
8 proceed to discuss in detail the two attachments  
9 to your submission, would you go back to the bottom  
10 of page 5, that suggestion No. 1. The Chairman  
11 questioned you about that, and I don't want there  
12 to be any misunderstanding. It is limited to the  
13 prescription of drugs in hospitals by hospital staffs.

14 DR. ROSS: That is correct.

15 THE CHAIRMAN: It is not general?

16 DR. ROSS: No, it is not general. It  
17 is under our programme that all necessary drugs are  
18 included in the hospital programme, and in order to  
19 consider the cost being borne by the taxpayers we  
20 are attempting to keep the cost of these drugs at  
21 a minimum level.

22 THE CHAIRMAN: This does not apply to  
23 private prescriptions?

24 DR. ROSS: No, just to hospital pres-  
25 criptions.

26 I would hesitate to speak for the  
27 profession, but I would feel that it would not be  
28 difficult to have the medical profession behind any  
29  
30



1 programme that would allow the implementation of  
2 that suggestion No. 1, where unless the doctor  
3 specifically states that the trade name is to be  
4 used the pharmacist could substitute, but, unfor-  
5 tunately, under the legislation, which I believe is  
6 a federal one, the pharmacist cannot do so, and we  
7 feel that is the reason that this recommendation was  
8 made to you, sir.

10 THE CHAIRMAN: Do you know, Doctor,  
11 whether in the profession in Alberta, there is a  
12 strong feeling that drugs are not equal even though  
13 they may be chemically the same, that some drugs are  
14 inferior, haven't been made with so much quality  
15 control, purity control as others, and when they  
16 are prescribed they are anxious that the exact  
17 prescription be provided but which in their opinion  
18 may not be so useful?

19 DR. ROSS: That is an opinion held  
20 by some doctors. Some in our own hospitals feel  
21 that way about certain types of drugs, and that is  
22 why we feel it is necessary that there should be  
23 rigid control of the compounding of these drugs by  
24 the manufacturing companies. I think with the  
25 chemicals being brought into Canada and manufactured  
26 in Canada that the Government can exercise the  
27 control over it. I know samples are taken and then  
28 analyzed, so there is a check being made at the  
29 time not only on these companies that are referred



to as bootleg companies as opposed to the ethical companies. I would think that, as in all cases, sir, there are men in the medical profession who are sold on the reputation that a company has and will feel that that company can do no wrong, and therefore they feel when they are prescribing that they have implicit trust in anything that is manufactured by that particular company, whereas they may not in the manufacture of other drugs by other companies. But I think that is changing, sir.

MR. FRAWLEY: Then, Dr. Ross, you have a report. One of the attachments is called Report of the Special Committee, Department of Public Health, Alberta, 1961, dealing with special drugs. Perhaps you would put that into the record by reading it and then comment on it.

DR. ROSS: Mr. Chairman, this is a report that was made to me by a Special Committee that I set up as an advisory committee to the Minister to consider the problem of certain special drugs, and this Committee was composed of the Professor of Medicine, Dr. Wilson, Dr. Gordon Brown, an internist - three internists and Dr. Wood also of our Medical Services Division at that time and is now part-time there, worked on this report.

This came about from letter that came in to my office that had been brought up in various provincial organizations in their annual conventions



1 with the recommendations that were forwarded on to  
2 the Government for consideration, and during this  
3 past most of four years I have been in that position  
4 I would say that there have been many organizations  
5 in this province that have sent in resolutions  
6 that are related to the cost of drugs, recommending  
7 that the Government give consideration to the provi-  
8 sion of drugs at least without charge to groups of  
9 our population.  
10

11                   This related mainly to old-age pension  
12 groups, and in this province we have what are known  
13 as supplementary pensioners who have additional  
14 pensions from the Government and along with it are  
15 provided with free medical care, free dental care,  
16 free optical care. I would say that in the dental  
17 care it is mainly in some areas where the patient  
18 has to pay something. But these people have had  
19 free hospital care, so they get their drugs free  
20 when they are inside hospital, but outside of hospi-  
21 tal they have to pay for them themselves. On the  
22 low income side there is a considerable amount of  
23 difficulty in them providing it out of their small  
24 income. They have free access to the doctors, so  
25 there is no question that they go to the doctors  
26 relatively frequently in the interests of their  
27 health, and the doctors naturally prescribe drugs.  
28 Oftentimes there is a beneficial effect in the  
29 advertising of the pharmaceutical companies that  
30



1 free samples can often be given to the patient and  
2 save them from buying them in the drugstore. How-  
3 ever, because of these circumstances a number of  
4 the provincial organizations have made representa-  
5 tions to the Government, and I have also had letters  
6 from individuals relating circumstances of cases of  
7 their own. These mainly were related to the corti-  
8 coid preparations.  
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dpw

The cortisone drugs that have been introduced during the past three years, as you know, are expensive drugs. In many cases they are life-saving drugs, and for that reason the patient who has a disease that will be benefited by the use of these is most anxious to secure it. The cost on the ordinary retail market of the normal dosage of the drug required for conditions that the steroid and corticoid drugs are useful in, will run anywhere from 40 to 60 dollars a month, and oftentimes higher. It was because of this that I had the Special Committee set up and had them make an investigation into it.

I would just like to read the report they made, and because of this report I have not proceeded any further with the investigation at the present time.

REPORT OF A SPECIAL COMMITTEE

DEPARTMENT OF PUBLIC HEALTH - ALBERTA - 1961.

Special Drugs

There is a group of serious chronic diseases whose common denominator is that steroids can control acute exacerbations and prolong life for an uncertain interval. The fact that the administration of steroids over long periods causes changes in the individual which are as serious as the original disease must be remembered. The effects on carbohydrate metabolism results in a



1 diabetic like condition.

2                   The production of a negative nitrogen  
3 balance requiring a high protein or high carbohy-  
4 drate diet with administration of supplementary  
5 potassium must be noted.  
6

7                   The production of a condition resem-  
8 bling Cushing syndrome with the typical "moon face"  
9 and "buffalo hump" is a calculated risk for the  
10 long-term patient. The interference with water  
11 and electrolyte metabolism resulting in oedema  
12 hypochloremia, hypo-kalemia, low-potassium syndrome  
13 and metabolic alkalosis are concomitants of conti-  
14 nued use of the steroids. The increased output of  
15 calcium and phosphorus cause osteoporosis or inten-  
16 sify that which previously existed to the point of  
17 causing pathological fractures.

18                   The effect of steroids in lowering  
19 inflammatory response while desirable in the speci-  
20 fic condition being treated renders the patient  
21 vulnerable in meeting stressful conditions such as  
22 surgery trauma and infection.

23                   The list of side effects might be  
24 continued to a gruesome infinity. However, hyper-  
25 tensive encephalopathy in sensitive children,  
26 peptic ulcer and the reactivation of quiescent  
27 pulmonary tuberculosis are real dangers. The  
28 responsibility of a third party in providing the  
29 drug is not to be dismissed lightly and demands a  
30



1 close and accurate clinical supervision during  
2 administration.

3 Since all illness is catastrophic to  
4 the individual and ultimate death is our lot; the  
5 branding of these conditions as catastrophic  
6 mainly because they are relatively rare and because  
7 the tablets (steroids) to palliate them, cost a  
8 patient between 88¢ and \$1.50 a day is a broadening  
9 of the definition of a medical catastrophe.  
10

11 THE CHAIRMAN: A financial catastrophe?

12 DR. ROSS: Quite right sir.

13 The reason the steroids cost so much  
14 would appear to be the price spread common to the  
15 pharmaceutical industry. We have Intra Prednisone  
16 25 mgm in 25,000 lots at 1½¢ per tablet as against  
17 22¢ per tablet in the retail trade.

18 The prime reason for the Department  
19 entering this field is to protect the patient of  
20 average income from the financial impact of a drug  
21 costing \$300.00 to \$400.00 per year.

22 I realise, sir, that in the Green  
23 Book, that it is recognized that there are many  
24 ways perhaps that people could save that amount  
25 of money to spend on drugs, but it does not mini-  
26 mize the fact that the drugs themselves are costly.  
27

28 THE CHAIRMAN: In the previous para-  
29 graph you refer to the fact that the steroid drugs  
30 cost so much, then you give an instance of a



1 variation of  $1\frac{1}{2}\phi$  per tablet buying large lots, and  
2  $22\phi$  per tablet in the retail trade. Is that what  
3 you call the price cost spread?

4 DR. ROSS: I wouldn't say that that  
5 applies in all drugs, but this is one instance that  
6 the Special Committee was investigating was the  
7 steroids, and this was a study being made to consi-  
8 der should we enter this field or should we not,  
9 and we realised it was the impact of the cost of  
10 these drugs from what it cost the pharmaceutical  
11 company to make them, and what the patient eventually  
12 had to pay in the retail market, if that is the only  
13 way they had of obtaining it.

14 THE CHAIRMAN: It indicates the price  
15 spread is 16 times as great for the individual  
16 patient to buy in the drugstore compared with large  
17 quantities purchased by hospitals.  $16\frac{1}{2}$  times the  
18 normal spread sounds quite high.

19 DR. ROSS: We find there is this  
20 spread in individual cases. My own personal  
21 remark would be this. I don't feel that the retail  
22 pharmacist is the one who is really to blame for  
23 this wide spread, as is quite evident with the  
24 various groups that this goes through.

25 THE CHAIRMAN: But there are a number  
26 of factors involved?

27 DR. ROSS: There are many factors,  
28 and certainly I would not want it to be taken that  
29  
30



1 as a Government we are criticizing the retail pharma-  
2 cists, because I feel there are many factors  
3 involved in the eventual cost, over which he has no  
4 control, and which might be able to be controlled to  
5 a greater extent if some of the suggestions that we  
6 make here, particularly that the pharmacist would  
7 be able to provide a similar drug rather than a  
8 trade name brand, because I am sure that if the  
9 retail pharmacists of this or any other province  
10 make a representation to you, they will point out  
11 that their shelves are often loaded with identical  
12 drugs of different trade name brands, because they  
13 have to fill prescriptions of many doctors, one of  
14 whom will prescribe one trade name another another,  
15 another another, all the same drug, and yet they  
16 have to have them in the store to fill the prescrip-  
17 tion, or get a supply from the wholesale drug company  
18 in order to fulfil their responsibility to their  
19 customers, and this results in a hold-over of stock  
20 they have paid for and cannot sell, so as a personal  
21 thing, and I am sure my colleagues would agree with  
22 me on this.

23  
24 To provide this drug to the 800 esti-  
25 mated patients suffering from these diseases, the  
26 committee has assumed that at least 400 would require  
27 the drug continuously at an average dose of four  
28 tablets (100 mgm of cortisone or equivalent) daily.

29 To set up the program, there would be  
30





1 more or less basic costs plus the cost per capita  
2 for supplying the drug.

3 Basic costs for a program covering  
4 the group of 400. Personnel approximately four  
5 hours daily including:

- 6 (1) Clinical assessment of applica-  
7 tions and periodic review (probably  
8 twice yearly)  
9 (2) Accounting  
10 (3) Stenographic  
11 (4) Shipping

12 The above would require addition of a  
13 full-time person to Medical Services' staff costing  
14 approximately \$300.00 per month, yearly cost  
15 \$3,600.00. The above is estimated from tolbutamide  
16 program covering about same number of individuals.

17 I will make reference to that later,  
18 sir.

19 From the same source, we can estimate  
20 cost of servicing as follows:

21 Mailing 400 5 mgm tablets  
22 prednisone every three  
23 months 20¢ x 4 - .80  
24 Packaging 5¢ x 4 - .20  
25 Cost of drug by bids in  
26 bottles of 400 laid  
27 down here (tablets) 5¢ x 400 x 4 - 80.00

28 Total cost of servicing  
29 per patient \$81.00 each x 400 - \$32,400.00

30 Basic Cost 3,600.00  
\$36,000.00



1 Cost of clinical assessment at request  
2 of Department. It should be pointed out that these  
3 patients are not covered by Benefit program or neces-  
4 sarily protected by prepaid medical schemes.

5 Clinical evaluation and minimal neces-  
6 sary investigation \$50.00 per patient per year.

7 This means there would be the necessity  
8 of having a competent internist do a thorough study  
9 of the patient with laboratory evaluation and testing,  
10 in order to follow the progress of the disease and  
11 the effect on that disease by the medicines provided.

12 These patients would be serviced as  
13 office patients by their own doctor. This figure  
14 does not include necessary treatment during the year,  
15 as these are a high usage group.

16 In other words, the patient is con-  
17 cerned about his illness and often goes back to his  
18 own doctor, and the \$50.00 does not include what he  
19 would pay his own doctor for the weekly or monthly  
20 visit.

21 Cost of clinical assessment  
22 per year \$50.00 x 400 - \$20,000.00

23 Estimated provincial assessment 4,000.00

24 Total cost of first year operation \$60,000.00

25 From the survey, it would seem that  
26 the net increase would be 140 patients per year.  
27 If one-half of these 140 required steroids cost of  
28 annual increment:  
29  
30



1	Drug and servicing - 70 x \$81.00 -	\$5,670.00
2	Clinical assessment - 70 x \$50.00 -	<u>3,500.00</u>
3		<u>\$9,170.00</u>

4  
5 Therefore, probably increase would be  
6 \$9,170.00 per year.

7 It must be noted that initially at  
8 least the costs could be doubled if all candidates  
9 for steroids were assessed and serviced.

10 Logically, it should be emphasized  
11 that these drugs are not cures and entering this  
12 field because of an economic problem not a medical  
13 one will inevitably lead to inclusion of all expen-  
14 sive drugs used for the palliation of chronic condi-  
15 tions.

16 THE CHAIRMAN: In arriving at the  
17 400 per year that would require steroids, and the  
18 probable 70 out of 140 increase, it is a result of  
19 your survey that about half of the patients would  
20 need to be serviced each year for a time, and then  
21 do not need it for a while, and have to come back  
22 on the drug?

23  
24 DR. ROSS: Some of them do not accept  
25 the benefit of a programme. Some of them, in spite  
26 of any advertising that may be done, are not aware  
27 of it, and do not come into the benefit of the pro-  
28 gramme. The fall-off in those that do not survive.  
29 Perhaps, if I may just indicate how this was  
30 arrived at. This was from Dr. Wilson, who was



1 Chairman of that Committee, a letter dated 31st  
2 January 1961: "I have now had an opportunity to go  
3 over the returns from the University Hospital, the  
4 Edmonton General Hospital, the Medicine Hat Municipi-  
5 pal Hospital and the Archer Memorial Hospital".

6 In taking those hospitals, we took  
7 the largest one, which has 1,200 beds, and about  
8 50% of the patients that go to that hospital come  
9 from the surrounding areas. Edmonton General  
10 Hospital, 70 to 80% of the patients are City of  
11 Edmonton patients, others in the near vicinity.  
12 Medicine Hat Municipal Hospital is down in the  
13 south and around a 265-bed hospital in a large  
14 rural area, and operates you might say as a  
15 regional hospital. The Archer Memorial Hospital  
16 at Lamont about 140 miles away, you might say is  
17 the typical large rural hospital, and the cases  
18 were taken from those areas to give a composite  
19 sort of study of the problem.  
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1 "...covering a five year period for  
2 those disease conditions in which steroid drugs  
3 might be considered a lifesaving measure, either as  
4 a continuous requirement or as periodic treatment  
5 programs.

6  
7 The total for these four hospitals  
8 over a five year period is 456 cases. During this  
9 five year period 36 of these patients died. To use  
10 round figures this would mean that in a five year  
11 period approximately 400 patients are still alive  
12 and under treatment and 40 have died. If our 'guesti-  
13 mate' is right, the figure for the whole province is  
14 probably twice this number in both categories. It,  
15 therefore, follows that the annual increment of new  
16 cases requiring steroid therapy would run to 160  
17 patients per year, and that of this number, 20  
18 patients per year would die.

19 If one could make another very large  
20 guess, it might be reasonable to state that half  
21 of all the patients under consideration might  
22 require steroid therapy all the time and that for  
23 purposes of arriving at some sort of figure, let  
24 us assume that the average daily steroid requirement  
25 is 100 mg. of Cortisone or its equivalent".

26  
27 And then he says he understands that  
28 on a contract basis Prednisone can be purchased in  
29 25,000 tablet batches from Entra Medical Products  
30 at a cost of 1.5¢ per 5 mg. tablet.





1 "On this basis, this would mean that  
2 the cost of drug therapy for this group of patients  
3 per year would roughly work out to \$8,700.00 per  
4 annum..."

5 "...If one were to take into consid-  
6 ration the annual increment and if only half of  
7 these required steroid therapy all the time, this  
8 would work out to approximately \$1,200.00 per year  
9 as an annual increment, taking into consideration  
10 those who would die during that period of time".

11 So that this Committee did go into  
12 a fair amount of investigation to try and give me  
13 the information and advice in regard to the problem  
14 I had to place with them.

15 To illustrate, sir.

16 The aldersterone antagonists at \$1.00  
17 per tablet, in cases of cirrhosis has cost the  
18 Department of Welfare up to \$150.00 per month for  
19 a patient of which I have knowledge.

20 This again, sir, was a patient that  
21 was treated by a competent medical authority in a  
22 rural area for a disease that they found was very  
23 much better by the use of this particular drug.  
24 The family could not pay for it and the Department  
25 of Welfare came into the picture to provide this  
26 drug so that this gives you some indication of  
27 many of these illnesses that the newer drugs are  
28 helpful in but that are also expensive in the normal  
29  
30



1 method of purchase that it presents a problem to  
2 which we have been trying to find the answer.

3 THE CHAIRMAN: Dr. Ross, is the  
4 Department doing this somewhat on an experimental  
5 basis or is this service held out to everybody  
6 that needs it?

7 DR. ROSS: I will come to that, sir,  
8 when I finish this.

9 The "umbrella" of antibiotics favored  
10 by some for prophylaxis and the topical and systemic  
11 steroids in atopic dermatitis are conditions that  
12 come to mind.

13 The realization that all the above  
14 possible program is being devised to circumvent the  
15 impact of an unreasonable profit by one industry  
16 upon about 800 citizens in the province leaves our  
17 approach open to question.

18 It would appear that a presentation  
19 to the pharmaceutical industry of the problem might  
20 provide these drugs at a reasonable price thereby  
21 leaving the responsibility for the provision and  
22 supervision of administration of these potent  
23 substances in the hands of the individuals. The  
24 inevitable widening of the program to an astrono-  
25 mical amount is the alternative.

26 I might just say here, sir, that for  
27 a number of years the Alberta Government has been  
28 providing insulin on a modified form of means test  
29  
30



1 to the people of Alberta.

2  
3 This goes back for many years when the  
4 cost of insulin was perhaps higher than it is today.  
5 As a lifesaving drug it was considered advantageous  
6 to see that anybody who had diabetes had this drug  
7 available to them. With the advances that have been  
8 made in the disease of diabetes, with the oral forms  
9 of drug therapy and with our population aging, many  
10 of them in the diabetic group having difficulty  
11 giving insulin to themselves because of failing  
12 vision and other infirmities, it was felt that the  
13 tolbutamide drugs may be useful when added to this  
14 drug programme so about a year-and-a-half or two  
15 years ago we added the tolbutamides to our programme.

16 We have worked out a method in which  
17 we also again have an assessment committee and a  
18 medical advisory committee in this programme. They  
19 have advocated certain tests that should first be  
20 made before the drug is prescribed. Then the first  
21 batch is sent to the doctor so he can have a proper  
22 relationship of patient-doctor for the control and  
23 knowledge of what is going on and then the supplies  
24 are sent out, I think, at three-month intervals.

25 It is interesting, sir, to note that  
26 on the diabetic tolbutamide therapy programme in  
27 1959 we bought close to 40,000 tablets from Horner  
28 at \$5.00 per 100.

29  
30 Hoechts Pharmaceuticals had orinides -



1 it's either that or the other way around - we also  
2 bought 39,000 from them at \$5.00 per 100.

3  
4 In 1960 Hoechts supplied 156,000 at  
5 \$4.80 per 100 then in 1961 156,000 at \$4.60 per 100.

6 The ordinary price of these is \$14.00  
7 per 100.

8 As the footnote indicates these  
9 prices are sales tax exempt and are in large volume  
10 sales.

11 The variation there is not very much.

12 Another programme that was implemented  
13 back in 1958 was the Rheumatic Fever Prophylaxis  
14 Programme.

15 As you are aware, the disease of  
16 rheumatic fever usually strikes young people,  
17 children, and has a detrimental effect on the heart  
18 and then this leads to - with repeated attacks -  
19 further damage on the heart and may leave them a  
20 cardiac invalid for the rest of their lives.

21 During the war it was found that  
22 streptococcal throats could be prevented by prophylaxis  
23 programmes of sulfonamides. Since the strep  
24 was considered to be a factor in the development  
25 of a recurrent attack of rheumatic fever, they  
26 had an experimental programme on the control of  
27 rheumatic fever episodes or recurrences by the use  
28 of sulfonamides.

29  
30 It was on the basis of the



1 experimentation that had been carried on over a  
2 period of years on the value of prophylaxis anti-  
3 biotics that we commenced our programme in Alberta  
4 for the prevention of recurrent attacks of rheumatic  
5 fever in 1958.

6  
7 At that time the price of penicillin  
8 tablets, which is the one that we chose, the  
9 440,000-unit tablets score, were selling in the  
10 drugstore at that time for around anywhere from 20  
11 to 25¢ apiece.

12 As you can see from this list the  
13 first year's 60,000 tablets by British Drug Houses  
14 cost us \$5.40.

15 THE CHAIRMAN: Per 100?

16 DR. ROSS: Per 100, down to 5¢ a  
17 tablet.

18 In 1959 60,000 from B.D.H. at \$5.00  
19 per 100. The same year we purchased another 130,000  
20 from B.D.H. and it came down to \$4.75 per 100.

21 In 1960 competition was coming into  
22 the picture a little bit more and Frank Horner got  
23 the bid.

24  
25 These are put out by our purchasing  
26 agency of the Provincial Government on bids and  
27 this time Frank Horner bid down to \$3.42 per 100  
28 for the 440,000-unit penicillin tablets.

29 Then in 1960-1961 192,500 tablets  
30 for which Frosst got the bid for \$2.95 per 100 and





1 then B.D.H. came along with a similar bid for a  
2 similar amount at \$2.95 per 100.

3 So certainly we have found this compe-  
4 titive bidding, merely setting up the dosage of the  
5 tablets that we want, the chemical included in it,  
6 has resulted in savings to the people of Alberta  
7 under this programme that have been very significant;  
8 that the cost per tablet for these amounts, which  
9 amounts are sales tax exempt, is about one-seventh  
10 of what the person will pay in the drugstore today.

11 THE CHAIRMAN: Do you know, Doctor,  
12 whether the price to the private patient in the  
13 drugstore has changed very much during the interim,  
14 1950 to 1961?

15 DR. ROSS: Not a great deal, sir.  
16 There has been a slight change. The price is  
17 \$19.25 per 100 which is just less than 20¢ per  
18 tablet. That is about what you are paying today in  
19 the drugstore, as I understand it.

20 THE CHAIRMAN: The reduction in the  
21 Government price under this programme has been  
22 something more than 40%. You do not think any-  
23 thing comparable to that has occurred as far as  
24 the private person is concerned?

25 DR. ROSS: I am quite sure it has  
26 not, sir.

27 I might say that we sometimes feel  
28 that perhaps there is an advertising advantage to  
29  
30



1 a pharmaceutical company to be able to say that  
2 this company's drugs are being used for a provincial  
3 programme, such as we have here in the Province of  
4 Alberta, the programme for rheumatic fever. Whether  
5 they write off some of the discounts they give us  
6 in advertising, I couldn't say.

8 This, Mr. Chairman, is the brief of  
9 the Province of Alberta. If there are any questions  
10 that you or the members of your Commission would  
11 like to give to us, I will try to answer them. If  
12 I cannot answer them, I hope that Dr. Rodman and  
13 Dr. Wood and Dr. Summerville may be able to give  
14 further information upon that.

15 BY MR. FRAWLEY:

16 MR. FRAWLEY: Dr. Ross, in the report  
17 of the Committee in connection with these steroid  
18 drugs, you spoke about a clinical evaluation. Where  
19 would that be done, the clinical assessment evaluation  
20 by applicants under review.

22 DR. ROSS: I think that would probably  
23 be done at our University Hospital. I think we have  
24 other hospitals in the Province with capable men and  
25 capable equipment in the southern part of the Province,  
26 as well as in the City here, that do it, but it  
27 would have to be done under a fairly rigid form of  
28 assessment and this should be done in the centre  
29 where they have the opportunity of making the neces-  
30 sary tests, clinical and laboratory tests.



1 MR. FRAWLEY: It would mean moving  
2 the patients in from their homes to one or two  
3 central places in the Province?  
4

5 DR. ROSS: Yes, that is right.

6 MR. FRAWLEY: They would move to  
7 the institutions. On the last page of the brief  
8 you have these two programmes, the Rheumatic Fever  
9 Prophylaxis Programme and the Diabetic Tolbutamide  
10 Therapy Programme. Are the drugs under those two  
11 programmes supplied free or at a small cost?

12 DR. ROSS: They are supplied without  
13 cost to the patient.

14 MR. FRAWLEY: Without cost at all.  
15 Then the steroid programme, if I may call it that,  
16 which was reported on by the Special Committee, has  
17 that ever been implemented?

18 DR. ROSS: No, it has not.

19 MR. FRAWLEY: It is under considera-  
20 tion at the moment?

21 DR. ROSS: My budgetary appropriation  
22 would have been extended well over, if I had under-  
23 taken it.

24 MR. FRAWLEY: Can you inform the  
25 Commission as to whether or not you are giving  
26 consideration to the enlargement of these two pro-  
27 grammes which are listed on the last sheet of your  
28 brief?  
29

30 DR. ROSS: Well, these two programmes,



1 the Rheumatic Fever Prophylaxis Programme and the  
2 Diabetic Tolbutamide Therapy Programme are well-  
3 established programmes in the Department. They will  
4 enlarge as demands are made upon them by the growth  
5 of our population and I am sure that they would not  
6 have been developed as a Government programme, at  
7 least not by our Government, if the cost of these  
8 drugs had not been so prohibitive to the general  
9 public, for the long maintenance that is required  
10 in the use of these drugs; but we do feel there is  
11 a responsibility to protect the health of our people  
12 and if there are drugs which are going to do that,  
13 that they cannot obtain through the normal retail  
14 channels because of excessive costs, as I mentioned  
15 before, it is not entirely the retail trade, I feel  
16 that the Government are going to have to give consi-  
17 deration to ways in which this can be accomplished.

18  
19 MR. FRAWLEY: I think that is all, Dr.  
20 Ross. Mr. MacLeod or the commissioners may have  
21 some questions to ask you.

22  
23 THE CHAIRMAN: I was going to ask a  
24 few questions, Dr. Ross, about the costs of the  
25 drugs of these two programmes on the last page; the  
26 Rheumatic Fever Prophylaxis Programme and the Diabe-  
27 tic Tolbutamide Therapy Programme; and the costs  
28 of the drugs, the \$2,000 a year in each case. It's  
29 not a very large amount; but you do not indicate  
30 what the other costs are in connection with these



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programmes so they can be compared with this other  
programme which the brief suggests would lead to  
astronomical figures.

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/dpw

1 DR. ROSS: I think, sir, that as far  
2 as some of the information on this other report,  
3 the accounting, the stenographic, the shipping, that  
4 information was arrived at by comparing the cost of  
5 the Rheumatic Fever Prophylaxis Programme with the  
6 Diabetic Tolbutamide Therapy Programme carried out  
7 in our Medical Services Division of which Dr. Wood  
8 has been assistant director during the past year.

9 THE CHAIRMAN: You mean the cost of  
10 these two programmes would be comparable with the  
11 other one?

12 DR. ROSS: Not quite. The mailing  
13 and the packaging, yes, which is approximately a  
14 dollar, perhaps around a dollar a year per patient.

15 Then the basic cost of the staff is  
16 required in carrying out this programme. But a  
17 large part of this cost, as you are aware, sir, is  
18 the cost of the drug there, \$80, and again the  
19 assessment of \$50 per patient a year. So the high  
20 cost of this programme is in the drug; the cost  
21 of the packaging and mailing is not too signifi-  
22 cant a cost.

23 THE CHAIRMAN: So the cost of the  
24 programme which is not adopted is very much higher?

25 DR. ROSS: Very much higher.

26 THE CHAIRMAN: In fact, several  
27 times higher at least?

28 DR. ROSS: Yes, that is right.



1 Because it is felt that the family doctor is normally  
2 reviewing the condition of his rheumatic fever  
3 patient, he knows they are getting the tablets, he  
4 is concerned with the health of this child who has  
5 had one bout or two bouts of rheumatic fever. The  
6 clinical assessment is carried out by the family  
7 doctor. To a large extent this applies to the dia-  
8 betic patient in other parts of the province. I  
9 would perhaps send the patient to a specialist and  
10 I would perhaps continue to do so unless I was  
11 aware of all the factors that are involved with  
12 the disease and also these very potent drugs which  
13 are used.

14  
15 MR. FRAWLEY: To sum up, in this  
16 special report of the Committee where you say in  
17 the fifth paragraph that this programme "demands  
18 a close and accurate clinical supervision during  
19 administration", that is where the distinction is?

20 DR. ROSS: Yes.

21  
22 THE CHAIRMAN: Mr. MacLeod, have you  
23 some questions you would like to ask Dr. Ross and  
24 his associates?

25 MR. MACLEOD: I think not, sir.  
26 But there were a couple of questions you raised,  
27 and Dr. Ross suggested Dr. Rodman deal with them.

28 THE CHAIRMAN: Perhaps Dr. Rodman  
29 then might give us some information on the point  
30 that I raised in connection with the paragraph on



1 page 2. The paragraph contains a good many conclu-  
2 sions of fact, and my question had to do with the  
3 sources from which these facts were obtained, parti-  
4 cularly because I felt quite sure that somebody  
5 here from the drug companies would raise some ques-  
6 tions on some of these things.

8 MR. FRAWLEY: I think it was on page 2,  
9 Mr. Chairman.

10 THE CHAIRMAN: Yes. These are conclu-  
11 sions of facts, and I wonder if the references given  
12 at the end are the sources or if there are some  
13 other sources.

14 DR. WOOD: Mr. Chairman, members of  
15 the Commission, these statements, while they possibly  
16 border on the philosophic, are substantiated by  
17 references. These statements have been made by quite  
18 a number of the literature investigated. For  
19 instance, the statement by Fallis, Ford in the New  
20 England Journal of Medicine, Limitations in the Use  
21 of Thiazide Diuretics, was used; the introduction  
22 of an oral diuretic was a distinctive advance to  
23 the people requiring this form of treatment, but  
24 the enthusiasm and the popularity which was well  
25 merited for the drug gives an example of the results  
26 of the chemists' work where they change one small  
27 atom in the molecule and the treatments are quite  
28 similar. But it gives an opportunity to the per-  
29 son reading the work. It has been suggested that  
30



1 it be marketed as a new work. The evaluation from  
2 the clinician's point of view as to absolute values  
3 and absolute improvements cannot be given in that  
4 short time. So the thiazides support the philosophy  
5 and the statements made on page 2. Those are not  
6 personal observations; these are taken as a consensus  
7 of opinion through a large portion of literature.  
8 The references given would give you a cross-picture  
9 of the opinion on both sides, an attempt by unbiased  
10 observers to evaluate the new points.

11  
12 THE CHAIRMAN: I wondered whether the  
13 list of references on page 6 - one was the Fallis  
14 and Ford - those are sources from which these state-  
15 ments were derived?

16 DR. WOOD: Yes, that is correct, sir.

17  
18 DR. ROSS: I would think, sir, that in  
19 some of these drugs mentioned Dr. Rodman as an inter-  
20 nist, a very capable one, could point out that the  
21 diseases that they are using are not the kind that  
22 you can see the results and make a proper evaluation  
23 over a short period of time; they are diseases which  
24 are oftentimes a chronic type of disease which does  
25 require the proper time for a proper evaluation of  
26 the drug. Sometimes at the start he has been wonder-  
27 fully hopeful and sometimes they don't turn out as  
28 they first appeared.

29 DR. RODMAN: Mr. Chairman, gentlemen,  
30 the practising internist is faced with a problem



1  
2 these days and that, let me say, if I may, that we  
3 are not blind to the picture, we see both sides,  
4 and what I attempt to do myself when a new compound  
5 is marketed is I note it, I put the price on a  
6 little card and put it in a drawer, and where cer-  
7 tain selective cases come along I use it. But by  
8 and large I find more and more I am tending to stay  
9 with the standard drugs of which I know the action  
10 and where the cost is less. Similarly, in these  
11 thiazide drugs where they happen to be the ones  
12 under discussion, the new ones have shown possible  
13 promise in the new work. Again I have learned as  
14 an internist in Western Canada I am better to take  
15 my time and let the large centres in Eastern Canada  
16 work it out and let the literature give me the  
17 advice I need. Where the treatment is short the  
18 cost is not of great significance, but where there  
19 is a heart condition the price is important and it  
20 behoves one to consider the cost of the drug.

21  
22 So that, sir, is my position. I am  
23 not anxious to rush into the widespread use of new  
24 drugs as they come on the market; I prefer to stay  
25 with the ones that I know and pass on the cost-  
26 saving.

27 THE CHAIRMAN: I suppose your posi-  
28 tion in that regard, Doctor, is based on the belief  
29 that many drugs come on the market before they have  
30 been adequately proved?





1 DR. RODMAN: Not necessarily - well,  
2 that is true, sir. The drugs that come on the market  
3 are normally, in most cases, by reputable houses  
4 where there is checking as to toxicity and minor  
5 action, but the minor variations are not known for  
6 many years.

8 THE CHAIRMAN: The side-effects?

9 DR. RODMAN: Well, minor variations  
10 or side-effects. In the thiazides, whether the  
11 potassium loss effect is the same with the original  
12 fluorothiazide, I think the opinion that is crystal-  
13 lizing in the last year is the difference is not so  
14 great and one might supply the cheaper compound,  
15 supply a little potassium which is cheap and therefore  
16 a saving to the patient.

17 As to toxicity in terms of skin rash  
18 and things like that, it hasn't been a significant  
19 factor; it has with some others.

20 If I might deviate, namely, in the  
21 position of the practising doctor as to what he can  
22 do to try and help his patients. Now, primarily I  
23 think his thoughts must be, one, that the drug has  
24 the action that he wishes; two, that it is safe for  
25 his patient. I think when there are no exceptions  
26 that cost must be secondary to those two primary  
27 conditions. So to my mind when I see a drug quoted  
28 at a much lower price the question raises itself  
29 to me: Where did it come from? Who made it? Who  
30



1 packaged it? Does the drug dissolve? Does it go  
2 through the internal tract, and does it break up  
3 into half-package instead of the original quantity?  
4 And I would like to know and have the assurance  
5 that the preparation I am using is satisfactory.  
6

7 It is my hope that the Federal Govern-  
8 ment will take steps to reassure us in this direc-  
9 tion in some of the cheaper preparations which are  
10 available.

11 Now, also this question of generic  
12 names comes up, and it is not as simple to my mind  
13 as we are led to believe.  
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1 It is said that if a doctor writes a  
2 generic name, that his patient will receive a cheaper  
3 compound. I have found that most of our pharmacists  
4 are only too happy to co-operate. I should not say  
5 most. As far as I am concerned, they all are happy  
6 to co-operate, but when you write a generic name  
7 you have no knowledge as to what preparation the  
8 patient receives. It then becomes the responsibility  
9 of the pharmacist to determine purity and source of  
10 supply.  
11

12 Also, I find that the patient on one  
13 occasion will receive a white tablet, on another  
14 occasion a yellow tablet, and they come to me and  
15 say: "I have not got the proper medicine. The drug-  
16 gist is no good". So, as the present arrangement  
17 stands, it means we must have prior arrangements  
18 with our pharmacist to have any idea what is being  
19 given. Certainly, if the preparation, if we could  
20 be sure that it was pure and packaged as expected  
21 in terms of weight, and as can be shown, studies  
22 have been made in the United States, there is consi-  
23 derable variation as to the drug contained in some  
24 of the preparations. If we could have an assurance  
25 that that was the case, then as a doctor we could  
26 do much to reduce the cost to our patients.  
27

28 THE CHAIRMAN: One other question  
29 that I asked while Dr. Ross was reading the brief.  
30 He referred to the active promotion of a drug with



1 its attendant ballyhoo, and a programme being initiated  
2 in the United States within a few weeks after an  
3 investigation started at the University Hospital in  
4 Edmonton. My question was whether you knew that no  
5 such investigation programme had been carried on in  
6 the United States prior to the ballyhoo in the United  
7 States, or whether they were relying on what was  
8 started in Edmonton as a basis for the ballyhoo?  
9

10 DR. RODMAN: This is like the case  
11 of the individual who burns himself on the stove  
12 once. He usually does not do it again. I know that  
13 Dr. Wilson and others associated with him found the  
14 same thing that I personally found. I was visited  
15 by a representative who assured me that this was a  
16 new product and they were looking for a primary  
17 investigation. In my innocence I agreed to do so  
18 and started a programme, only to find two months  
19 later that not only were there five other sources  
20 in Canada investigating it, the publications were  
21 coming in large quantities from the States.  
22

23 I think in all fairness though, that  
24 we ourselves walk into situations like that in  
25 Edmonton. I don't think we do that any more. We  
26 ask too many questions, and I would also say in all  
27 fairness to the drug firms that they now send their  
28 directors around, and these are honest and fair men,  
29 and no longer does one as a rule need to worry too  
30 much about this type of thing.



1                   The type of investigation that they  
2 are doing is carefully outlined, and with a few  
3 questions one can soon ascertain whether this is a  
4 primary research that is really desired, or merely  
5 a promotional campaign to acquaint you with the  
6 product.  
7

8                   THE CHAIRMAN: I was getting at  
9 whether there had been basic or primary research  
10 made previous to the promotion for sales purposes,  
11 and your comments indicate that they were asking a  
12 dozen or more research groups to conduct what they  
13 thought would be primary research into the same  
14 drug?

15                  DR. RODMAN: From my own experience  
16 I would say I undertook primary investigation of  
17 one drug at the request of a Canadian firm, but I  
18 didn't know, and I take it as my error, that I  
19 didn't search the literature, although I think it  
20 was not in publication to within a short time of  
21 beginning work. Another company in the United  
22 States was working on this material. That is not  
23 unusual with a new drug.  
24

25                  THE CHAIRMAN: That is there was  
26 some research?

27                  DR. RODMAN: Definitely, and I feel  
28 that the firm that asked me in this particular case  
29 were aware of it.  
30

                  THE CHAIRMAN: But it is far more





1 objectionable from your point of view I suppose for  
2 them to start ballyhooing the sale on your research  
3 before it is completed? Is that the situation?

4 DR. RODMAN: It meant you just wash  
5 out two months' work.

6 THE CHAIRMAN: But you wouldn't want  
7 to be party to a promotion for sale of something  
8 which you were investigating but had far from  
9 completed your research, because your results might  
10 be very different?

11 DR. RODMAN: That is right sir.

12 MR. MACLEOD: In addition to being a  
13 medical doctor, are you also a qualified pharmacist?

14 DR. RODMAN: Yes sir.

15 MR. MACLEOD: Do you teach at the  
16 University touching on the subject of instructing  
17 prospective doctors in the uses of drugs?

18 DR. RODMAN: Yes sir.

19 MR. MACLEOD: So that you could say,  
20 perhaps without modesty, that you are an authority  
21 on this field?

22 DR. RODMAN: Possibly.

23 MR. MACLEOD: And you have a continuing  
24 interest in it?

25 DR. RODMAN: Yes.

26 MR. MACLEOD: Are not you yourself  
27 able to express an opinion that will be of value  
28 to the Commission on the statements made at page 2.  
29  
30



1 You don't have to go to any authorities outside  
2 your own experience, do you? Aren't you in a posi-  
3 tion to see when drugs come on the market and whether  
4 there is a background of literature on their effects  
5 available, and so on?  
6

7 DR. RODMAN: Yes, definitely.

8 MR. MACLEOD: In your opinion, based  
9 on your own experience, are those statements correct  
10 that are made there?

11 DR. RODMAN: I think so sir.

12 MR. MACLEOD: In this matter of testing,  
13 there was a witness suggested that in his experience  
14 there was what he called a hierarchy of testers.  
15 He said if a new product was likely to be a real  
16 wonder drug, it was going to the top investigators  
17 in the field in North America, whereas if it was of  
18 doubtful validity you would see reports from people  
19 you never heard of. Does your experience indicate  
20 anything along those lines?

21 DR. RODMAN: I don't think so. It  
22 is true that the large investigations are carried  
23 out more in Eastern Canada and in the eastern United  
24 States, where larger numbers of clinical patients  
25 and clinical material is available, and the research  
26 investigative units are much larger. It is not fair  
27 for us in Western Canada to make remarks, because  
28 research is only now beginning to develop to any  
29 degree out here. It is moving very rapidly, and  
30



1 will soon be in force. It is true you have fringe  
2 investigations, but primary, basic research I don't  
3 think is limited to any one area.

4 MR. MACLEOD: In your experience, what  
5 is the time factor in obtaining information from the  
6 manufacturers and obtaining information about the  
7 same drug from the journals, that is in the case of  
8 a new product being introduced on the market?  
9

10 DR. RODMAN: Oh, it takes six months  
11 to a year to obtain much volume of literature, so  
12 that you can form a reasonable opinion.

13 MR. MACLEOD: Are you speaking of  
14 literature in the journals now?

15 DR. RODMAN: Yes.

16 MR. MACLEOD: Are you likely to get  
17 the manufacturer's literature as soon as the drug  
18 comes on the market?

19 DR. RODMAN: No, yes, a certain amount  
20 of it. There are always usually a half-a-dozen  
21 series of investigations in the better products  
22 that are available quite early.

23 MR. MACLEOD: Do you find the litera-  
24 ture issued by the manufacturers useful to you in  
25 your work?  
26

27 DR. RODMAN: What kind of literature?

28 MR. MACLEOD: The promotional litera-  
29 ture, direct mail literature, that is mailed out to  
30 you?



1 DR. RODMAN: Maybe I can take that  
2 down a bit further. Some of the promotional litera-  
3 ture that comes along with articles by other men I  
4 find valuable. The literature that comes along in  
5 a single page with a lot of red ink and so on, I  
6 merely pass over my desk into the trash can.

7  
8 MR. MACLEOD: Can you make any esti-  
9 mate of the percentage of promotional literature  
10 which you receive which you find of real value?

11 DR. RODMAN: It is hard to put a  
12 percentage, I would say not very much.

13 MR. MACLEOD: Would over half of it  
14 go in the wastepaper basket?

15 DR. RODMAN: Oh, yes, yes. I might  
16 add in that respect that some of the drug represen-  
17 tatives that do come around do give us concrete  
18 literature and drugs and papers that is a help, but  
19 I am referring strictly to material that is mailed.

20 MR. MACLEOD: Touching on the point  
21 you just raised, what is your experience with the  
22 detail men, or the medical representatives? Do  
23 you find that they give you valuable information?

24 DR. RODMAN: Well, their kind, you  
25 take 50% of it and throw the rest away, and the  
26 50% that you take you sit and wait to see what  
27 comes up.

28  
29 MR. MACLEOD: Do you find that there  
30 are so many of these people that they are a nuisance,



1 and impinge on your time?

2 DR. RODMAN: No, they are very respec-  
3 table and courteous people. Many of them are very  
4 helpful in a new preparation. If there is a defect  
5 that shows up they are very honest and tell me when  
6 it comes. It is true that there are a few that you  
7 might wish didn't come, but they are a very carefully  
8 selected group. I think probably their biggest  
9 fault is that they are so enthusiastic about their  
10 preparation, and they must be, or they wouldn't be  
11 of any value to their firm.

12 MR. MACLEOD: Incidentally, in instruc-  
13 ting your pupils, the prospective medical graduates,  
14 do you teach drugs by generic name or trade names?

15 DR. RODMAN: Oh, no, by the generic  
16 name, and the trade name is merely given for purposes  
17 of identification. We are stressing the use of the  
18 generic names, the metric system, and the metric  
19 dosage to our students, and also the question of  
20 cost has a part of every drug discussion that I  
21 make.

22 MR. MACLEOD: Is it difficult for a  
23 doctor to keep up with the cost of drugs?

24 DR. RODMAN: Well, it was difficult  
25 until I started the small card index system that  
26 I have in my righthand drawer. Each new product  
27 that comes in I ask the price to the patient, and  
28 I note it down on the card. If I am in doubt I  
29  
30



1 'phone one of my pharmacist friends and find out  
2 about the product or its equivalent that might be  
3 cheaper.  
4

5 MR. MACLEOD: Of course you go to a  
6 great deal of trouble to maintain this system?

7 DR. RODMAN: No, it is no trouble.  
8 When the individual comes to see me they all have  
9 a card. It is a simple matter to jot the price  
10 down and file it in its place.

11 MR. MACLEOD: Are you able to express  
12 any opinion on whether doctors generally know the  
13 cost of drugs they prescribe?

14 DR. RODMAN: Yes, I think I can. I  
15 think six months or a year ago they were horribly  
16 deficient in this field. I think that attitude is  
17 changing very rapidly and they are becoming very  
18 conscious of the cost. Certainly among the interns  
19 they are exceedingly conscious of the cost.  
20

21 MR. MACLEOD: I suppose any doctor  
22 would realise of course that if he prescribed corti-  
23 sone for some rheumatic condition it was going to  
24 cost the patient considerably more than if he pres-  
25 cribed ASA tablets, and certainly most antibiotics,  
26 so that there are within the drugs available classes  
27 that almost any doctor would be bound to know this  
28 is expensive and this is relatively cheaper?

29 DR. RODMAN: There should be.

30 MR. MACLEOD: I direct your attention





1 to the last paragraph on page 2 of the brief. I  
2 take it that paragraph expresses the opinion that  
3 the testing of drugs should not be the testing of  
4 all new drug products - should not be carried out  
5 by educational government bodies? "It does not  
6 seem practical or desirable to suggest that educa-  
7 tional or governmental bodies be asked to perform  
8 clinical evaluation of all drugs produced". Is  
9 that because of the volume of these products? Is  
10 that with respect to all new products on the market?  
11  
12  
13  
14 -  
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20 -  
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22  
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30 -



C/dpw

1 DR. RODMAN: I think there are a  
2 number of things. One is the volume is large and  
3 the time that is required is also large and also it  
4 is difficult to obtain trained technicians for this  
5 type of work in scattered areas. It needs to be  
6 centralized or at least at one or two major areas.  
7

8 DR. ROSS: If I may amplify on that --

9 MR. MACLEOD: Yes, Dr. Ross.

10 DR. ROSS: This is a Government brief.  
11 This is the opinion of our Government: besides  
12 being experimental and being involved in the Univer-  
13 sity we feel that the free enterprise system can  
14 competently do this and that there should not be a  
15 passing over of this responsibility to centralized  
16 authority.  
17

18 MR. MACLEOD: Those are all the points  
19 I want to raise at this time.

20 THE CHAIRMAN: There was one point I  
21 had, it is not a question. The Commission, I think,  
22 would be interested in perhaps for comparison pur-  
23 poses having the total cost to the Government of  
24 the drugs it supplies and the per capita cost, if  
25 those could be readily made available.

26 DR. ROSS: I can get them for the  
27 Commission, sir. I do not know whether Dr. Wood  
28 has had a chance to get a list of the number of  
29 patients we have. We can easily get this for you,  
30 sir, and supply it to you.



1 MR. FRAWLEY: That is what is meant,  
2 that it should be supplied.

3 THE CHAIRMAN: I do not suppose you  
4 would have it with you today but if it could be  
5 done very readily --  
6

7 DR. WOOD: There will be one area that  
8 will be very hard to evaluate. The fact that the  
9 welfare responsibility is shared by the municipali-  
10 ties and by the Province and that it is difficult  
11 to extract from their budgets the amount that goes  
12 to that.

13 The only way you will be able to do  
14 that would be if we could include the drugs provided  
15 by the hospital and the drugs that are provided  
16 under these various programmes, I think we can come  
17 to a fairly accurate total and then it would be  
18 divided population-wise.

19 THE CHAIRMAN: I think that would be  
20 useful and certainly interesting to us.

21 Mr. Whiteley asked by any chance have  
22 you got any special tabulation available with  
23 respect to the mental hospital patient?  
24

25 DR. ROSS: We would have the cost of  
26 the drugs supplied to our mental hospitals.

27 THE CHAIRMAN: That would be entirely  
28 a provincial matter?

29 DR. ROSS: Yes, that is entirely a  
30 provincial matter. Our two large mental hospitals



1 and then we have three smaller areas plus two  
2 mental defective institutions. I can get a breakdown  
3 of the cost of drugs for the years - depending for  
4 how many years you would like to have it.

5 THE CHAIRMAN: We certainly would not  
6 want you to go back to antiquity. We have had some  
7 figures relative to other provinces for the past  
8 three years.

9 DR. ROSS: I will have Dr. Summerville  
10 get those figures available for institutions, the  
11 number of patients, the daily average of patients  
12 and the cost of drugs. We can draw from our hospi-  
13 tal programme in its implementation for perhaps the  
14 last two years, 1959 and 1960, sir. I could get  
15 the number of patient days, the total cost of drugs.  
16 This certainly would not be entirely accurate but  
17 it would be close enough to be useful.

18 THE CHAIRMAN: And perhaps it would  
19 be reliable enough not necessarily down to the last  
20 decimal point.

21 MR. FRAWLEY: We will certainly pre-  
22 pare as much as we can, sir, and supply it to you.

23 THE CHAIRMAN: Thank you very much,  
24 Doctor and gentlemen. We appreciate very much the  
25 effort you have made in your presentation today and  
26 I am sure we will find it very helpful in considering  
27 these problems.

28 MR. MACLEOD: Would the Commission like  
29  
30



1 to hear from Mrs. Marliss now?

2 THE CHAIRMAN: Yes, Mrs. Marliss.

3 MRS. MARLISS: Gentlemen: As Presi-  
4 dent of the Alberta Branch of the Canadian Associa-  
5 tion of Consumers, I am here today, at the direction  
6 of my executive committee, to tell you that our  
7 members are vitally concerned about the high prices  
8 being charged Consumers for certain classes of the  
9 newer Ethical Drugs. We are grateful for this  
10 opportunity to speak before this Commission, for  
11 the Consumers of this province.  
12

13 After hearing all the experts that  
14 have been presenting their submissions this morning,  
15 I have a very real inferiority complex.

16 First of all, I would like to make  
17 our position clear. We, as laymen, do not pretend  
18 to be authorities in this highly technical field  
19 dealing with pharmaceutical products. The fact is  
20 that in addition to receiving reports and complaints  
21 from our members we have done some limited research  
22 and have questioned a number of authorities and  
23 technical experts for our own information. Gentle-  
24 men, I admit to you quite frankly that we have  
25 found almost as many opinions as experts, and a  
26 very wide difference of opinion. However, we did  
27 find that there was general agreement in the  
28 opinion that the price of drugs is too high.  
29

30 THE CHAIRMAN: Not only in this field





1 that happens?

2  
3 MRS. MARLISS: Yes, I know.

4 As you know, our National President  
5 of the Canadian Association of Consumers has  
6 already presented a brief to you during your  
7 sittings in Ottawa. As members of this organiza-  
8 tion, we are pleased to record that we are in  
9 complete agreement with the general policy as it  
10 was presented to you by Mrs. Plumptre.

11 When a Consumer goes to purchase  
12 drugs by prescription, he is in a vastly different  
13 position than when he makes any other purchase.  
14 He may make a choice between lettuce or cabbage,  
15 silk or wool, or between a Ford or a Chevrolet; or,  
16 if the product is not sufficiently appealing he may  
17 refrain from making any purchase whatsoever. On  
18 the other hand, when a Consumer goes to purchase a  
19 drug on the direction of his physician, this is  
20 usually at a time of illness of either the purchaser  
21 or a member of his family. His alternative to buying  
22 the drug prescribed is to do without, at the risk of  
23 his health or perhaps even his life. We have had  
24 reports of persons who unfortunately did not make  
25 purchases of ordered drugs, simply because they  
26 found the price prohibitive.

27  
28 After listening to Dr. Ross' state-  
29 ment I think we must get a lot more publicity about  
30 the welfare drugs that are available because I am





1 sure this is not as widely known as it might be.

2 Therefore, we find the consumer with  
3 little or no knowledge of the product he is buying,  
4 and no idea of what a reasonable price should be.

5 That is why we feel, that in this  
6 matter of drugs, more than any other, the Consumer  
7 has the right to expect some authoritative protec-  
8 tion as to both price and quality. Under the Food  
9 and Drug Act there is some protection of quality  
10 and standards (I will say more about this later).  
11 But where price is concerned, the consumer is at  
12 the discretion and the mercy of both his physician  
13 and the whole drug industry, from the manufacturer  
14 to the pharmacist. After studying a report of the  
15 Submission of the Director of Investigation and  
16 Research, we certainly have the impression that many  
17 of the prices charged to the Consumer are neither  
18 reasonable nor fair. On the basis of the Submission  
19 we believe the Government of Canada has more than  
20 enough evidence to warrant taking some action to  
21 remedy this situation. We therefore conclude that  
22 the purpose of this hearing is to give citizens, as  
23 well as groups concerned with the drug industry, an  
24 opportunity to express their views and to offer  
25 suggestions. We would therefore offer for your  
26 consideration our opinion of some of the factors  
27 which are contributing to the present high cost of  
28 drugs.  
29  
30



1 First we would say patent laws.

2 Most of the drugs sold in Canada are  
3 imported chiefly from the United States, where  
4 their laws at present give complete monopolistic  
5 control of the sale of drugs, to the patent-holder  
6 or drug manufacturer. Thus, the Canadian consumer  
7 has no choice but to pay the price at which U.S.  
8 manufacturers supply these drugs to the Canadian  
9 market. Even when the drugs are produced in Canada -  
10 usually by subsidiaries of American companies - the  
11 price structure is still controlled by the primary  
12 patent-holder. We realize that we have no control  
13 over American patents, but we respectfully request  
14 this Committee to examine our Canadian laws concer-  
15 ning patents and licenses, with a view to suggesting  
16 changes to end this monopolistic control of the drug  
17 market. Just as an example of the effect of our  
18 present patent laws, I would cite an item which was  
19 reported to us. Parke-Davis, Chloromycetin, a  
20 common drug used for children, sold for about \$6.50  
21 for a two-ounce bottle. When the patent ran out,  
22 and a number of companies began producing this drug,  
23 the price by Parke-Davis was reduced sharply from  
24 \$6.50 to \$3.50.

25 In the brief that you have there when  
26 I say when the patent ran out - my information was  
27 incorrect at the time this was printed. I under-  
28 stand there were licenses issued to other companies  
29  
30



1 to produce this particular drug and it was not a  
2 case of the patent running out but there were addi-  
3 tional licenses introduced.

4 THE CHAIRMAN: Our patent laws in  
5 Canada do provide for compulsory licensing.

6 MRS. MARLISS: They are not very effec-  
7 tual at the moment.

8 THE CHAIRMAN: They appear not to have  
9 been used as much as might have been anticipated.

10 MRS. MARLISS: That is right.

11 GENERIC OR BRAND NAMES

12 For several years now we have been  
13 hearing that hospitals, public institutions, govern-  
14 ment agencies, and welfare organizations have been  
15 purchasing drugs by their generic names at a much  
16 lower price than Brand Name products. Gentlemen,  
17 as a layman I would like to ask why, if it is advi-  
18 sable and desirable for institutions to purchase  
19 and use drugs without regard for their brand names,  
20 then why, is it not advisable for the individual  
21 consumer to have the advantage of the same substan-  
22 tial saving in price?

23 I was interested in noticing that  
24 Dr. Morrell that the physician has no knowledge of  
25 the drug when the generic name is used. He mentioned  
26 something about he didn't know about the solubility,  
27 the disintegration of a drug.

28 I was interested to read a report made  
29  
30



1 by the Food and Drug Division. They have done some  
2 research on pill disintegration and there are very  
3 rigid standards applied to both the generic name  
4 drugs and the brand name drugs.  
5

6 Dr. Morrell, in his testimony to you  
7 in Ottawa, did not differentiate between the quality  
8 of Brand Name Drugs or Generic Name Drugs. And we  
9 do know that Food and Drug inspectors check both  
10 kinds in the same way. To quote Dr. Morrell:  
11 "There are good and bad products sold under 'brand'  
12 names. The criterion should be the facilities,  
13 ability, and attitude of the manufacturer - not the  
14 name".

15 Consumers are asking whether it is so  
16 important that the drugs come from manufacturers who  
17 are well-known. We are primarily concerned about the  
18 safety, the quality and the control of the drugs.  
19 It doesn't make any difference to us whether the  
20 manufacturer is in Canada, the United States, Europe  
21 or Japan. Consumers in North America are conditioned  
22 to relying on "brand names" as an automatic symbol  
23 of high quality. We suspect that this same influence  
24 has affected the attitude of both physicians and  
25 pharmacists. Unfortunately, the evidence does not  
26 always justify this blind faith. We are particularly  
27 concerned that this attitude leads to a faulty  
28 conclusion: that, since Brand Named Drugs must be  
29 good, then those "not branded" or those sold under  
30



1 Generic names must automatically be inferior. There  
2 are still some people who pay 89¢ a 100 for Aspirin  
3 tablets, when they could buy 250 ASA tablets (the  
4 same thing exactly) for 69¢. Prejudices and atti-  
5 tudes are very difficult to overcome and change. As  
6 a resident of this province I am pleased to commend  
7 the Calgary Albertan Newspaper for the series of  
8 articles entitled "The Truth about Drug Prices"  
9 which they published last year. These articles  
10 served a useful purpose in enlightening many people  
11 about generic name drugs. Bearing in mind that we  
12 want high quality, safe drugs, at the lowest possible  
13 price, we would recommend that a wider use of the  
14 generic names in drugs be facilitated and encouraged.  
15 This, as we see it, is a very complex problem invol-  
16 ving not only the availability of these products but,  
17 also, the co-operation of physicians and retail phar-  
18 macists.  
19

20 I might say as a consumer organization  
21 we feel we have a part we might play in that regard  
22 too.  
23

#### 24 STANDARD AND QUALITY CONTROL

25 We mentioned earlier that the consumer  
26 has some protection of quality and standards of  
27 drugs. We are well aware of the fine work done by  
28 the staff of the Food and Drug Directorate, and we  
29 are confident that they have legislative powers to  
30 ensure that standards of quality are maintained.





1 But legislative powers are not enough if the Direc-  
2 torate is hampered by insufficient staff for both  
3 research and testing, and also for inspection. We  
4 would recommend therefore that the staff of the Food  
5 and Drug Directorate be increased to permit it to  
6 fulfil its role as guardian of quality and standards.

7 ADVERTISING AND PROMOTION

8  
9 We are well aware that it is necessary  
10 to advertise, in order to publicize the existence  
11 of new products. But we wonder whether it is neces-  
12 sary to spend as much as between 25% to 40% of the  
13 value of net sales, for promotional purposes. This  
14 promotion is directed to the medical profession,  
15 and pharmacists, whom we would consider to be intelli-  
16 gent and reasoning individuals. We were pleased to  
17 hear from a number of these doctors that they consi-  
18 dered much of the promotion and advertising material  
19 to be not only excessive, but a nuisance. If some  
20 of this costly advertising could be curtailed then  
21 perhaps the price to the consumer might be lessened.  
22 We would like to mention the practice of offering  
23 not only samples, but quantities, of certain items  
24 for the personal use of doctors. We were pleased  
25 to note that you had heard a brief from at least  
26 one professional man, on this subject, and we are  
27 sure that he presented this matter much more effec-  
28 tively than we, as laymen, could do.

29  
30 I know this is a very acceptable





1 promotion scheme to doctors. We feel that doctors  
2 are in a position to pay for a good many of the  
3 things they need and if they are getting these  
4 samples at the expense of the consumers, we wonder  
5 whether that is entirely justified.

6  
7 RETAIL DRUG TRADE

8                   The Investigation and Research Report  
9 states that there is virtually no price competition  
10 in the sale of ethical drug products at the retail  
11 level. This statement must be accepted by the consu-  
12 mer as a matter for real concern. We have been told  
13 also, that in this community - it might be similar  
14 elsewhere too - it is a common practice when a  
15 prescription is withdrawn by the consumer (usually  
16 in an effort to shop around for a lower price) for  
17 the druggist to mark a coded price on the prescrip-  
18 tion, for the guidance of other druggists. We  
19 consider this a deplorable practice, which is costly  
20 to the consumer.  
21  
22  
23  
24 -  
25  
26  
27 -  
28  
29  
30 -



pw  
1 And yet, at this time citizens are  
2 enjoined by the Pharmaceutical Association to feel  
3 deep gratitude for all the benefits of modern drugs.  
4 But we could be just as grateful if the cost to us  
5 did not represent such a handsome profit not to  
6 discoverer but to the distributors and merchandisers  
7 of the new drugs.  
8

9 In this great country of ours, we  
10 are particularly sensitive to major disasters. I  
11 notice Dr. Ross called it a catastrophe. When there  
12 is news of human suffering we respond individually  
13 and collectively to offer help. May we suggest that  
14 severe illness, with all its accompanying physical  
15 suffering and financial drain, can be a very real  
16 personal disaster. Those who suffer, often through  
17 no fault of their own, deserve more consideration.  
18 That is why we feel that a reduction in the price  
19 of drugs would provide a much needed relief.  
20

21 THE CHAIRMAN: Mrs. Marliss, would you  
22 care to make any further comments on the brief?

23 MRS. MARLISS: No. I purposely withheld  
24 facts in the report given to us because some of them  
25 were highly emotionally coloured. We did check on  
26 the information and we found that they were substan-  
27 tially the same as many of the figures that were  
28 presented here. So I am sure you will appreciate  
29 if we don't make any more repetitions. You have  
30 heard these statements all across Canada.



1                   That is all I want to say, unless you  
2 have some questions.

3                   THE CHAIRMAN: Mr. MacLeod?

4                   MR. MACLEOD: I have no questions,  
5 sir.

6                   MR. WHITELEY: Mrs. Marliss, on page  
7 5 in the section dealing with Advertising and Promo-  
8 tion you make some comment on the distribution of  
9 samples and your brief states that these are for  
10 the personal use of doctors.

11                   MRS. MARLISS: No, I said samples as  
12 well as for the personal use, did I not? "Not  
13 only samples, but quantities, of certain items for  
14 the personal use of doctors".

15                   This I have seen in medical journals.  
16 I have gone over to the medical library and browsed  
17 around to get the information, and I have seen items  
18 such as: "We will send you enough of this as you  
19 want". Baby foods was an example I saw the other  
20 day, and I think they are capable of paying for  
21 the medical food they need for their children, and  
22 if this is added to the promotional cost of adver-  
23 tising --

24                   THE CHAIRMAN: Most of the evidence  
25 has been with regard to the drugs themselves, not  
26 to the samples.

27                   MRS. MARLISS: We have had examples  
28 where they are given to people who are not able to  
29  
30



1 pay for them.

2 MR. WHITELEY: We have seen other  
3 examples where they are provided by the drug firms.

4 MRS. MARLISS: Yes. I don't know  
5 how significant this is in the cost, but I know  
6 they are there.

7 THE CHAIRMAN: It is the opinion that  
8 they cannot reach the public unless they do engage  
9 fairly extensively in advertising programmes, so  
10 we have to find where the dividing line ought to  
11 be drawn.

12 MRS. MARLISS: Yes, that is your job.

13 THE CHAIRMAN: Thank you, Mrs. Marliss.

14 MR. MACLEOD: Would you like to hear  
15 the Canadian Mental Health Association now?

16 THE CHAIRMAN: If there is no urgency,  
17 I wonder if we could hear Reverend Taylor. I gather  
18 that Reverend Taylor has not very much time, and I  
19 suggested if he were here between 11 and 12 we  
20 might fit him in.

21 Would it be fair to you gentlemen to  
22 hear him first?

23 MR. ROBINSON: Yes, sir.

24 THE CHAIRMAN: May we have your full  
25 name?

26 REV. TAYLOR: Edward Rex Taylor.

27 THE CHAIRMAN: And your church is?

28 REV. TAYLOR: MacDougall United Church,  
29  
30



1 sir.

2  
3 THE CHAIRMAN: Yes, Mr. Taylor.

4 REV. TAYLOR: May I express my appre-  
5 ciation, sir, to your good self and your court for  
6 giving me this brief opportunity and to the gentle-  
7 men here for coming at this time in the programme.

8 I want to speak very briefly on three  
9 headings. I cannot speak with any detailed informa-  
10 tion such as the previous speaker; I am not a drug-  
11 gist, and I can only speak in general principals in  
12 this problem which confronts us in this great nation.

13 The first thing I would like to say -  
14 and again I would comment that I am not a druggist -  
15 the first thing is I think the prices of drugs in  
16 other countries are cheaper than in Canada. I will  
17 give you two instances: the price of ASA tablets.  
18 For a comparative price in England I can buy five  
19 times the quantity of ASA tablets as I can buy in  
20 Canada. I think in the United States certain gene-  
21 ric-named drugs are considerably cheaper than in  
22 Canada.

23  
24 The second thing is this. In my  
25 practice as minister I have come across numbers of  
26 cases, and I can document this if you so wish, of  
27 people in this city in my congregation who have  
28 died in greater pain than need be because they  
29 cannot afford the price of drugs. I am not refer-  
30 ring to people in distressing circumstances or on



1 public relief; I am referring to the backbone of  
2 the nation, the hard-working citizen who has a  
3 standard job. I can only speak for the great need  
4 for lowering the prices of drugs.

5  
6 The third thing is that there is in  
7 this city a firm of druggists who are selling drugs  
8 cheaper than other firms and they are having pres-  
9 sure put on them from the wholesalers and their  
10 supplies of drugs are drying up. I have this on  
11 good information, and I think we ought to commend  
12 people who are endeavouring to do this sort of  
13 thing.

14 That is all I wish to say. I am sorry  
15 I have not had the opportunity of putting this on  
16 paper in brief form. If you wish it retrospectively,  
17 I will be happy to do so.

18 THE CHAIRMAN: With respect to this  
19 firm which is having pressure put on it, have you  
20 specific information, factual information as to  
21 what sort of pressure is being put on it?

22  
23 REV. TAYLOR: I have, sir, and again  
24 I have this information on good authority, but I  
25 have it in confidence and I would have to break the  
26 confidence of people in the profession, and I would  
27 not like to do that. I would be happy to put it on  
28 paper. But I have it on good authority that there  
29 is a firm in this city whose prices are less than  
30 others in the city and their supplies are being





1 curtailed from the wholesalers. In the absence of  
2 documentary evidence, if you wish to disregard this  
3 testimony I am happy to stand in the judgment of  
4 your court.

5  
6 THE CHAIRMAN: We are anxious to make  
7 use of this type of information. We need to have  
8 it documented, at least proved by evidence which we  
9 can use as firsthand.

10 REV. TAYLOR: I can say that I was in  
11 myself last week and I tried it out on three other  
12 firms, and the firm is, in fact, underselling them  
13 on my own experience. Their prices are considerably  
14 lower.

15 THE CHAIRMAN: What we are concerned  
16 with in this inquiry, because of the terms of our  
17 Act under which we operate, is to ascertain not  
18 simply whether the price of drugs is high but if  
19 they are high why they are high, and if there is  
20 some restrictive practice and monopolistic situation,  
21 and the pressure on people to keep their prices up  
22 often means some restrictive practices and that is  
23 why we need some sort of data.

24  
25 REV. TAYLOR: I understand that, and  
26 that is why I can only speak in the restricted  
27 circumstances I referred to.

28 THE CHAIRMAN: If you care to get the  
29 information to us in written form we would be happy  
30 to follow it up.



1 REV. TAYLOR: I will seek to do so.  
2  
3 It will possibly be withheld because they themselves  
4 are engaged in the medical and druggist professions.

5 THE CHAIRMAN: Thank you very much,  
6 Mr. Taylor.

7 REV. TAYLOR: I am grateful for your  
8 indulgence.

9 THE CHAIRMAN: Mr. MacLeod, we now  
10 have a brief from the Alberta Division of the Cana-  
11 dian Mental Health Association?

12 MR. MACLEOD: Yes, sir. I am not sure  
13 who is presenting it. I was talking to Mr. Grant-  
14 Smith on the 'phone.

15  
16 SUBMISSION OF THE CANADIAN MENTAL  
17 HEALTH ASSOCIATION

18 Appearances: B.L. Robinson, President,  
19 Alberta Division, C.M.H.A.

20 G.M. Grant-Smith, Secretary,  
21 Scientific Planning Committee.

22 MR. ROBINSON: Is it your desire,  
23 Mr. Chairman and members of the Commission that I  
24 read our brief?

25 THE CHAIRMAN: I think you should  
26 read it and make any comments as you go along or  
27 at the end as you see fit.

28 MR. ROBINSON: This brief is prepared  
29 by The Alberta Division of the Canadian Mental  
30 Health Association for presentation to the Restrictive



1 Trade Practices Commission in the course of an  
2 inquiry under section 42 of the Combines Investiga-  
3 tion Act relative to the Manufacture, Distribution  
4 and Sale of Drugs.

5  
6 The Alberta Division of the Canadian  
7 Mental Health Association wishes to draw to the  
8 attention of the Commission some factual observa-  
9 tions regarding the effect of the high cost of  
10 psychiatric medicines on the maintenance of mental  
11 health by former mental patients.

12 Our Association is not in a position  
13 to express an opinion on the fairness of the selling  
14 price of these drugs. The Commission has access to  
15 information bearing on this point in the statement  
16 of materials collected by your Director and Investi-  
17 gation and Research.

18 Our observations are based on the  
19 close contact of our staff and White Cross Centre  
20 Committee at Edmonton in the past three years with  
21 more than 600 discharged mental patients and briefer  
22 contacts with another 1,400 patients or members of  
23 their families (as noted later in this brief).  
24 These observations have been augmented by discussions  
25 with most of the psychiatrists in private practice  
26 in Edmonton.

27  
28 Of the above 40 percent were depen-  
29 dent on medication for maintenance of mental health  
30 and at least 30 percent of all contacts have



AG/dpw

1 reported financial difficulties in securing prescribed  
2 medications.

3  
4 I think that could be partially  
5 explained by the fact that these people, for a  
6 considerable period of time their earning capacity  
7 is reduced or eliminated.

8 THE CHAIRMAN: I suppose the medica-  
9 tion, to have the desired effect, would be taken  
10 over a period?

11 MR. ROBINSON: That is right.

12 It should be noted that medication  
13 prescribed for mental illness will probably be  
14 required for a greater length of time than medica-  
15 tion for any other form of illness except insulin  
16 for diabetes.

17 We have noticed that to many patients  
18 (both those discharged from provincial hospitals  
19 and those who have been treated by private psychia-  
20 trists) the cost of the drugs prescribed seems so  
21 prohibitive that they will not even attempt to  
22 start their use.

23  
24 Many others who do start find the  
25 burden of their regular purchase so heavy that  
26 other living costs gradually are given priority  
27 and the drug purchases are diminished or dropped,  
28 with the result that regression follows and  
29 hospitalization is again necessary.

30 It should be noted that while the



1 psychiatric teams in our mental hospitals and  
2 clinics are more successful every year in treating  
3 mental illness, nevertheless, about 50 percent of  
4 those discharged as able to return to normal living  
5 will be readmitted to the hospitals in the future.  
6 Some of these readmittances are to be expected nor-  
7 mally, as in any other illness, but many are the  
8 result of conditions facing the former patient in  
9 the community or the family.

11 In view of the fact that at least 30  
12 percent of the ex-patients in contact with our White  
13 Cross Centre have had some difficulty in securing  
14 prescribed medication - and that these difficulties  
15 lead to regression in many cases - we are confident  
16 that an important proportion of readmissions to  
17 Canadian mental hospitals could be prevented if  
18 psychiatric medication were more readily and easily  
19 available.

21 The Canadian Mental Health Association  
22 in this community uses a considerable part of its  
23 budget and energy in assisting discharged mental  
24 patients to re-establish themselves in the community  
25 and maintain their mental health and social integra-  
26 tion. This part of our programme is carried on  
27 through our White Cross Centre.

28 In the past three years our White  
29 Cross Centre Supervisor and other staff members  
30 have had fairly close contact with more than 600



1 discharged mental patients. The office is visited  
2 by some 130 people every month (around 500 new  
3 contacts each year) seeking advice, help or referral  
4 in connection with problems they meet in re-esta-  
5 blishing themselves in the community.  
6

7 About 63 percent of these former  
8 patients come from the provincial mental hospitals  
9 in Alberta, about 5 percent from the Psychiatric  
10 Ward of the University of Alberta Hospital and  
11 another 5 percent come from hospitals in other  
12 provinces. About 25 percent are referred to us by  
13 private practitioners or psychiatrists and about 2  
14 percent are referred by other agencies or persons  
15 in the community.  
16

17 That means other welfare services, or  
18 somebody who refers a relative or a friend to us.

19 Officially, when a patient is dis-  
20 charged from a provincial mental hospital he no  
21 longer has access to the hospital's supply of drugs.  
22 Medication prescribed as necessary to maintain his  
23 mental health must be secured by his own resources  
24 through purchases from retail outlets, or be  
25 secured through welfare facilities in his own  
26 community.  
27

28 The discharged patient who is unable  
29 to pay for his drugs must pass the same means test  
30 as for any other welfare assistance. The most  
generous in existence in this province is that set





1 out for the Out Patient's Clinic of the University  
2 of Alberta Hospital. Under this a single man may  
3 not be earning more than \$120.00 a month, a married  
4 man may not earn more than \$150.00, with \$20.00  
5 additional for each child, to be eligible for treat-  
6 ment or medication through this clinic.

7  
8 THE CHAIRMAN: Does that mean they  
9 couldn't be treated through that clinic at all?

10 MR. ROBINSON: Free. I believe they  
11 can go to the clinic, but on a free basis they have  
12 to maintain this prescribed means test.

13 This means that under the most generous  
14 terms available in this province a married man with  
15 four children is not eligible for assistance if he  
16 is earning more than \$230.00 a month. The White  
17 Cross Centre has a record of one such man whose  
18 total income before taxation is less than \$300.00  
19 a month, out of which he has to pay \$20.00 a month  
20 for medication to maintain his mental health. This  
21 patient also requires about eight consultations  
22 with a private psychiatrist every year.

23  
24 Another White Cross contact while  
25 steadily employed at a small salary had the oppor-  
26 tunity to write a qualifying examination for a  
27 better position with a higher salary. Preparing  
28 for the examination he was overcome by anxiety and  
29 emotional depression. He was put in touch with a  
30 psychiatrist who prescribed Trilafon. The



1 psychiatrist advised us that if he did not secure  
2 this medication immediately, further hospitalization  
3 would be necessary. Our contact did not have enough  
4 money on hand to purchase a ten days' medication  
5 supply but fortunately we were able to secure medi-  
6 cation with the aid of another agency and the patient  
7 rallied well and was able to take his examination.  
8

9           Also, through the White Cross Centre  
10 we have information on a middle-aged woman who was  
11 discharged from the provincial mental hospital  
12 during the summer of 1960 on a maintenance dose of  
13 Stelazine. She has been employed as a housekeeper  
14 by a working mother with five children. Her total  
15 cash remuneration is \$40.00 a month, the cost of  
16 her medication is at least \$15.00 per month. This  
17 proved to be an almost insurmountable problem for  
18 this woman and the probability is that the stress  
19 will ultimately send her back for further hospitali-  
20 zation.

21           Though some private psychiatrists  
22 who confine their practice to neuroses do not use  
23 medication to any great extent, the majority of  
24 private psychiatrist's patients are likely to be  
25 affected. These include many people who, although  
26 with modest incomes, attempt at all costs to be  
27 independent. Some psychiatrists report that they  
28 prescribe drugs for from 25 to 45 percent of all  
29 their cases at a minimum monthly cost of \$20.00  
30



1 per patient.

2  
3 A patient who contacted the Canadian  
4 Mental Health Association office was being treated  
5 for various physical ailments and a developing  
6 psychiatric condition. Her general physician and  
7 her psychiatrist who was trying to avert a breakdown,  
8 had also prescribed a number of medications, inclu-  
9 ding folic acid. The total cost of these prescrip-  
10 tions exceeded \$50.00 a month.

11 Her husband's income was less than  
12 \$5,000 a year and the strain on their resources  
13 created a dangerous stress. Some relief of their  
14 condition was received when the physicians were  
15 contacted by a community welfare worker and they  
16 agreed to re-write the prescriptions in generic  
17 terms rather than using trade names for the  
18 required medication.

19 Another psychiatrist reports the  
20 difficulty that faces many patients suffering  
21 from severe depression. He usually prescribes an  
22 eight to ten-week course of medication with  
23 "psycho-energizers" which would cost the patient  
24 from \$4.00 to \$6.00 a day. In his experience  
25 about 30 percent of his patients find it impossible  
26 to meet this expense.

27  
28 Respectfully submitted.

29 THE CHAIRMAN: That last course of  
30 medication, if it had to be taken every day, would



1 run to about \$120.00 to \$140.00 per month?

2 MR. ROBINSON: That is correct.

3 THE CHAIRMAN: Have you any further  
4 comments you would like to make?

5 MR. ROBINSON: I have no further  
6 comments, but Mr. Smith, our Executive Director,  
7 may have.  
8

9 MR. SMITH: Well, it is our point in  
10 presenting this brief, simply to underline the  
11 fact that this area, which is not thought about as  
12 much possibly as others, the price of the drugs is  
13 a very, very real problem, and one that to the  
14 person, as mentioned in the brief, a person who is  
15 on his own, a person who is eligible for welfare,  
16 who is really hard up, probably the needs will be  
17 met, but it is a very important thing in the matter  
18 of returning the mental patient to the community,  
19 and his recovery, and his convalescence, that this  
20 matter of being self-supporting and independent is  
21 something that is very important to the development,  
22 to the return to better mental health. The patient  
23 that is forced into a dependant position very often  
24 we notice that they are the ones who fail to hold  
25 their mental health, and probably show regression,  
26 and have to come back eventually to the hospital,  
27 so that this question of the price of the drugs  
28 and their availability to the patient has several  
29 effects on the patient.  
30



1 THE CHAIRMAN: Mr. MacLeod, have you  
2 any questions?

3 MR. MACLEOD: No sir.

4 MR. FRAWLEY: Mr. Chairman, shall I  
5 question further? The gentleman who read the brief  
6 is Mr. Robinson?

7 MR. ROBINSON: That is right.

8 MR. FRAWLEY: Would you tell the  
9 Commission further about what you call the White  
10 Cross Centre, what it is physically and what it  
11 consists of? Your brief says that you at the White  
12 Cross Centre attempt to rehabilitate the discharges  
13 from mental hospitals and so on, but do you have a  
14 separate building? Could you tell us something  
15 about it?  
16

17 MR. ROBINSON: We maintain a White  
18 Cross Centre in connection and in conjunction with  
19 our office in the City of Edmonton, and the provin-  
20 cial office. Also one under the Alberta Division  
21 in Calgary. We learn in advance when patients are  
22 going to be discharged from the hospital in the  
23 next few months, and we have a bus with which we  
24 bring them to Edmonton, and we bring these patients  
25 into our White Cross Centre and get them interested  
26 in things outside the hospital. We have many acti-  
27 vities, social and handicraft and it gets these  
28 people, who have been confined to the hospital, out  
29 of that hospital atmosphere, so that they can  
30





1 become members of the community. After being  
2 discharged they will come back to us sometimes for  
3 many months until they are able to get back into  
4 their niche in society. The activities are in  
5 charge of Mrs. Oliver, who is here with us today,  
6 who is a psychiatric nurse, and she and Mr. Smith  
7 and the doctor members of our staff are available  
8 to these patients when they come.

10 MR. FRAWLEY: The reason I ask that  
11 question is that you show a very commendable  
12 interest in these discharges obtaining drugs.  
13 Have you attempted at all to set up dispensaries  
14 of your own, where the drugs could be obtained at  
15 less than the cost to them in the retail drugstores?

16 MR. ROBINSON: No, we have not.

17 MR. FRAWLEY: You have not investi-  
18 gated or canvassed those possibilities at all?

19 MR. ROBINSON: No we haven't.

20 MR. FRAWLEY: Are you aware that the  
21 two drugs you have mentioned, that is, Trilafon,  
22 the generic name of which is perphenazine, is  
23 discussed fully in the Director's report, commonly  
24 called the Green Book, at pages 194 and 195, and  
25 the second drug that you speak of, Stelazine, is  
26 discussed at page 201, the generic name of Stela-  
27 zine being triflupromazine, sold by Smith Klein  
28 and French. Have you examined the costs there  
29 shown, the costs of those drugs as disclosed in  
30





1 the Green Book?

2 MR. ROBINSON: No I haven't.

3 MR. SMITH: We have not attempted to  
4 make any interpretation.

5 MR. FRAWLEY: I do not pretend to  
6 know anything about the legal organization or set-up  
7 of the Canadian Mental Health Association but would  
8 you be in a position to buy drugs as a result of  
9 competitive bidding from the manufacturers for the  
10 operation of dispensaries for those people who  
11 find it difficult to obtain their necessary supplies  
12 in the ordinary retail outlets?

13 MR. ROBINSON: To the best of my  
14 knowledge our Association has never attempted to  
15 go into the dispensary of drugs in any way, shape  
16 or form.

17 MR. FRAWLEY: You regard the inability  
18 to obtain these drugs for these patients once they  
19 are out of hospital as a serious matter.

20 MR. ROBINSON: Very much so.

21 MR. FRAWLEY: That is pretty obvious  
22 from your brief.

23 MR. ROBINSON: Yes. The people are  
24 dependent upon these drugs to live a normal life  
25 or as near normal as possible.

26 MR. FRAWLEY: All you can do is to  
27 send them to the retail outlet with their own  
28 resources to purchase these drugs?



1

MR. ROBINSON: That is correct.

2

3

MR. FRAWLEY: I was interested in

4

your statement on page 3 when you stated that some

5

relief in the condition of a particular patient

6

was obtained when the physicians were requested by

7

a community welfare worker to re-write the pres-

8

cription in the generic terms.

9

Can you be a little more specific

10

about that? Can you tell us what the drug was and

11

what the re-writing of the prescription was?

12

MR. ROBINSON: Personally I cannot.

13

I will have to ask our Director. Are you in a

14

position to answer that question, Mr. Smith?

15

MR. SMITH: I am not sure of the drugs.

16

The welfare worker to whom I referred was in the

17

courtroom a few minutes ago. She will be back

18

this afternoon.

19

MR. FRAWLEY: It can be followed up.

20

I was only seeking it for the information of the

21

Commission. I was wondering, because you did

22

indicate, that the mere re-writing of the prescrip-

23

tion in the generic terms just that in and of

24

itself brought about some relief to the patient.

25

You mean financial relief?

26

MR. ROBINSON: That is right and

27

enabled her to live a more active life.

28

MR. FRAWLEY: You are not able to

29

tell us the drug?

30



1 MR. ROBINSON: We will get that.

2 MR. FRAWLEY: That information is  
3 available and will be supplied?  
4

5 MR. ROBINSON: We can supply it, yes.

6 THE CHAIRMAN: Mr. Robinson, for the  
7 record, your Association is not in any sense suppor-  
8 ted by Government, it is strictly a voluntary associa-  
9 tion?

10 MR. ROBINSON: Yes. My connection is,  
11 yes.

12 THE CHAIRMAN: I do not mean you do  
13 not have employees. As far as you are concerned,  
14 you are not supported by Government funds?

15 MR. ROBINSON: No. We participate in  
16 the United Community Fund and the Alberta Government  
17 also gives us a provincial grant each year.

18 THE CHAIRMAN: You have some financial  
19 support of that kind?

20 MR. ROBINSON: Oh yes, very much so.

21 THE CHAIRMAN: You are not in the  
22 position, I gather, to consider the dispensing of  
23 drugs to patients?  
24

25 MR. ROBINSON: No. We do work very  
26 closely with a lot of the other social service  
27 organizations. Naturally we come in contact with  
28 cases that take us to the Family Service Bureau  
29 and organizations of that type. In that way our  
30 office does work very closely with other community



1 welfare groups.

2 THE CHAIRMAN: I see one example of  
3 that mentioned in the brief.

4 MR. ROBINSON: That is right.

5 THE CHAIRMAN: A person was going to  
6 take an examination and was unable to get the drug  
7 and you got in touch with some other agency and  
8 they were able to get a supply to him?

9 MR. ROBINSON: That is right.

10 THE CHAIRMAN: So you do work in that  
11 way?

12 MR. ROBINSON: That is right.

13 MR. FRAWLEY: Do you receive any  
14 grants from the Federal Department of the National  
15 Health and Welfare?

16 MR. ROBINSON: We do not but our  
17 National Association does.

18 MR. FRAWLEY: You are a member of  
19 the National Association?

20 MR. ROBINSON: Yes, we are.

21 MR. FRAWLEY: That is the kind of  
22 organization they are, a sort of semi-public orga-  
23 nization.

24 THE CHAIRMAN: They do get some  
25 support but it was not intended to let them branch  
26 into the drug field.

27 MR. FRAWLEY: That is something  
28 about which I may make some representations at the  
29  
30



1 end of the year.

2 THE CHAIRMAN: I gather from what Mr.  
3 Robinson has said what the sources of revenue are.

4 MR. FRAWLEY: I understand quite well  
5 what they do now, that is true.

6 THE CHAIRMAN: Has any member of your  
7 delegation anything further they would like to add?  
8 I don't think there are any more questions from  
9 the Commission.

10 MR. ROBINSON: I don't believe so,  
11 sir.

12 THE CHAIRMAN: Well, we will then  
13 adjourn until 2.15 p.m. this afternoon.

14 --- The hearing recessed until 2.15 p.m.  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30



1 --- On resuming at 2.15 p.m.

2  
3 THE CHAIRMAN: Mr. MacLeod?

4 MR. MACLEOD: Dr. Weinstein, I believe,  
5 of the Podiatry Association is prepared to make a  
6 presentation at this time.  
7

8 THE CHAIRMAN: Dr. Weinstein, would  
9 you come forward please.

10 DR. WEINSTEIN: Yes, Mr. Chairman.

11  
12 SUBMISSION OF THE ALBERTA PODIATRY ASSOCIATION

13 Appearances: Dr. F. Weinstein, Legislative  
14 Chairman, Alberta Podiatry Assn.

15 Dr. John Paran.

16 THE CHAIRMAN: Yes, Doctor.

17 DR. WEINSTEIN: Mr. Chairman, I repre-  
18 sent the Alberta Podiatry Association, and I would  
19 like to submit that the brief we have submitted  
20 herein be tabled for a matter of record and I will  
21 speak to it extemporaneously and stress some of  
22 the points.

23 In the Matter of the Alberta Pharma-  
24 ceutical Association Act, 1945, and

25 In the Matter of the Food and Drug  
26 Act, being Chapter 123, R.S.C. 1952, and

27 In the Matter of the Proprietary or  
28 Patent Medicines Act, being Chapter 220, R.S.C.  
29 1952, and  
30





In the Matter of the Opium and Narco-  
tic Act, being Chapter 201, R.S.C. 1954, and

In the Matter of the Canadian Bill of  
Rights Act, being Chapter 44 R.S.C. 1960, and

In the Matter of the Podiatry Profes-  
sions Act, being Chapter 12 in Statutes of Alberta,  
1952, and

In the Matter of the British North  
America Act, being Chapter 15, R.S.C. 1952, and

In the Matter of the Combines Investi-  
gation Act, being Chapter 314, R.S.C. 1952.

WHEREAS the members of the Alberta  
Podiatry Association are empowered under enabling  
legislation to examine, diagnose and treat all  
ailments that fall in that branch of the healing  
arts;

AND WHEREAS the proper examination,  
diagnosis and treatment of such ailments requires  
the use of pharmaceutical compounds and products;

AND WHEREAS the Alberta Pharmaceutical  
Association 1945, the definition of "Prescription"  
does not include a direction given by a member of  
the Podiatry profession of a remedy for a disease  
or disorder, prescribing the ingredients with or  
without a method of using, insofar as the Act is  
concerned;

AND WHEREAS regulations under the  
Food and Drug Act, being Chapter 123, R.S.C. 1952



1 define "Practitioner" as a person authorized by the  
2 law of the province of Canada to treat patients with  
3 any drug named or included in the parts of these  
4 regulations;  
5

6 AND WHEREAS the Canadian Bill of  
7 Rights Act being Chapter 44, R.S.C. 1960 defines  
8 these "rights" to include the right of the individual  
9 to equality before the law and the protection of the  
10 law;

11 AND WHEREAS the Opium and Narcotic  
12 Drug Act being Chapter 201, R.S.C. 1952 fails to  
13 include or make any mention whatsoever of a Podia-  
14 trist;

15 AND WHEREAS the Proprietary or Patent  
16 Medicine Act being Chapter 220, R.S.C. 1952 fails  
17 to place any prohibition regarding any individual  
18 respecting the purchase or use of any drug included  
19 under this Act;

20  
21 AND WHEREAS the British North America  
22 Act being Chapter 15, R.S.C. 1952 defines property  
23 and civil rights as being within the exclusive  
24 powers of provincial legislatures, and the regula-  
25 tion of trade and commerce to the parliament of  
26 Canada;

27 NOW THEREFORE the Members of the  
28 Alberta Podiatry Association would submit the  
29 following information and proposals for your  
30 earnest consideration.



1  
2 1. Object of the Brief:

3 It is earnestly desired that this  
4 Commission should give serious consideration to the  
5 recommending of amending the definitive section of  
6 the Opium and Narcotic Act to include Podiatrists  
7 as persons who may give a direction of a remedy for  
8 disease or disorder insofar as that Act is concerned.

9 It is earnestly desired that this  
10 Commission give serious consideration to the recom-  
11 mending to the Federal Cabinet to disallow the provi-  
12 sions of section 22 and the various provincial  
13 Orders-in-Council issued thereunder as being an  
14 invasion of federal legislation respecting trade  
15 and commerce.

16 2. Reasons for Submission:

17 a. Since 1952 members of the Podiatry  
18 profession have been recognized by this Province as  
19 persons who are competent to treat disorders and  
20 diseases of the human foot. As a result of this  
21 move, registered Podiatrists have been writing  
22 prescriptions during the examination, diagnosis and  
23 treatment of such ailments. These prescriptions  
24 were compounded by members of the Alberta Pharmaceu-  
25 tical Association.

26  
27 However, it is now recognized that  
28 the definitive section of the Alberta Pharmaceutical  
29 Association Act 1945 does not include Podiatrists.  
30 The Food and Drug Act R.S.C. 1952 through regulations



1  
2 made pursuant to the provisions of that Act defines  
3 "Practitioner" as a person authorized by the law in  
4 a province to treat patients with any drug named or  
5 included in Appendix IV and Appendix V through  
6 these regulations.

7 Reference A. 02.020 of the Food and Drug Act Regu-  
8 lations.

9 The regulations under the Food and  
10 Drug Act also describe "Prescription" as being the  
11 Order of a practitioner directing that a stated  
12 amount of any drug or mixture of drugs specified  
13 therein to be dispensed for a person named in such  
14 order.

15  
16 b. In 1959 section 22 of the Podiatry  
17 Professions Act was introduced by the provincial  
18 government in Alberta to provide for some drugs to  
19 be used, bought or prescribed by a Podiatrist and  
20 whose prescriptions for such drugs were authorized  
21 to be filled by a registered pharmacist. O.C.  
22 1680/60 published as Alberta Regulation 352/60 lists  
23 a specific schedule of drugs which Podiatrists are  
24 authorized to purchase and supply to their patients  
25 and to write prescriptions to be filled by any phar-  
26 macist.

27 c. It would appear that provisions  
28 of the various Federal Acts and regulations and of  
29 the definition sections of the Alberta Pharmaceuti-  
30 cal Association Act and the Podiatry Professions



1 Act are in conflict.

2 d. It would appear that provisions  
3 of the Opium and Narcotic Act by omitting any  
4 mention whatsoever of a Podiatrist or Podiatry is in  
5 conflict with the provisions of the Canadian Bill of  
6 Rights Act by failing to provide equal recognition  
7 under the law to the members of this profession.  
8

9 e. It would appear that the section  
10 22 which was enacted by the provincial government  
11 of Alberta in the Alberta Podiatry Professions Act  
12 is in conflict with the Federal Proprietary and  
13 Patent Medicines Act by failing to qualify the mem-  
14 bers of the Podiatry profession to buy, and use any  
15 drug included in that Act, as well as prohibiting  
16 any pharmacist from selling any Proprietary or  
17 Patent Medicine not listed in O.C. 1680/60 to any  
18 Podiatrist in Alberta.

19 f. It would appear that the entire  
20 purpose of section 22 is in direct conflict with  
21 section 91 of the British North America Act which  
22 assigns trade and commerce to the federal jurisdic-  
23 tion. Hence this section is ultra vires, to the  
24 provincial legislature for lawful enactment.  
25

26 g. Under section 2 (aa) of the  
27 Combines Investigation Act "business" means the  
28 business of manufacturing, producing, transporting,  
29 purchasing, supplying, selling, storing or dealing  
30 in articles; and section 2 (a) defines "article"



1 means an article or commodity that may be the sub-  
2 ject of trade or commerce; it is respectfully  
3 submitted that any provincial legislation which pro-  
4 hibits or interferes in the supplying or purchasing  
5 of any drug by any licensed Podiatrist is ultra  
6 vires to this Act. That any druggist who aids and  
7 abets such violation is also guilty of an offence  
8 under this Act by interfering with legitimate rights  
9 of any Podiatrist to purchase or supply his patients  
10 with any drug under this section of federal legis-  
11 lation.  
12

13 3. Effect of Present Conflict between Federal and  
14 Provincial Legislation regarding right to Buy,  
15 Use and Prescribe Drugs

16 a. The failure on the part of the  
17 federal authorities to accord equal recognition  
18 under the law to Podiatrists to use or prescribe  
19 narcotics, deprives the members of this profession  
20 and their patients the benefits of this class of  
21 drugs.  
22

23 b. It also unnecessarily restricts  
24 the choice of drug to provide relief of pain and  
25 thereby limits the sale of these drugs as well as  
26 the reduction in cost which such recognition would  
27 bring about.

28 c. The Alberta provincial authorities  
29 have clearly violated the definition of the Alberta  
30 Podiatry Professions Act by adding section 22 and





1 in doing so invade the federal field by attempting  
2 to define who may purchase or sell various drugs.

3  
4 d. The failure on the part of both  
5 provincial and federal authorities to accord the  
6 members of this profession their legal rights to  
7 buy, use and prescribe various drugs greatly  
8 reduces the number of duly authorized and qualified  
9 persons who may do so. This restricts the sale of  
10 such drugs and thus adds to their cost to the ultimate  
11 consumer.

12 e. In the United States where members  
13 of the Podiatry profession have been invited to  
14 serve on an advisory panel to the National Formulary,  
15 an international drug reference and authority  
16 recognized by Canadian federal authorities, this  
17 has resulted in grants for research by the pharmaceutical  
18 manufacturers. As a consequence there has  
19 been a greater use of recognized remedies and a  
20 resultant drop in price of these drugs by virtue of  
21 their greater volume of sales.

22  
23 f. The failure on the part of both  
24 provincial and federal authorities to accord proper  
25 legal recognition to use any drug for the examination,  
26 diagnosis or treatment of an ailment of the  
27 human foot serves to restrict the flow of funds  
28 from Canadian drug manufacturers and distributors  
29 to enable research along similar lines. As a  
30 consequence our Canadian consumer is obliged to pay



1 a higher price due to a monopoly, illegally maintained.

2  
3 4. Proposals:

4 a. It is respectfully submitted that  
5 serious consideration be given to recommending that  
6 the Opium and Narcotic Act be amended to include  
7 "Podiatrists" as a person licensed to tender a  
8 prescription or order for any narcotic.

9 b. That this Commission suggest that  
10 the conflict in federal and provincial legislation  
11 may readily be clarified by declaring section 22 of  
12 the Alberta Professions Act ultra vires and simul-  
13 taneously adding the name of this profession in the  
14 Alberta Pharmaceutical Act as duly qualified to  
15 issue an order or prescription for any drug or  
16 compound to be filled by a registered Pharmacist.

17 c. The adoption of these proposals  
18 would provide a greater outlet for all classes of  
19 drugs, thus increasing the sales base which leads  
20 to a reduction in prices.

21 d. Since the educational qualifica-  
22 tions of a Podiatrist regarding drugs, basic  
23 sciences, clinical sciences not only exceeds that  
24 of the dentist but in a good many instances equals  
25 that of the physician, no lessening of standards  
26 for the protection of the public is involved.

27  
28 First of all, I should like to bring  
29 to the attention of this Commission that podiatrists  
30 are recognized throughout the English-speaking



1 world and they are established by statute in this  
2 province as they are in most provinces in Canada.  
3 Secondly, they are empowered by law to use certain  
4 drugs. The right to use these drugs has in some  
5 cases been circumscribed, and the circumscription  
6 affects both the practitioner and the public; it  
7 affects them with respect to the choice of their  
8 drugs and the price of drugs. Thirdly, that in  
9 their choice of drugs and this circumscription it  
10 affects the advertising and the public is deprived  
11 of certain drugs, and we will cite certain instances  
12 in which drugs we are empowered to use are less than  
13 half in the United States as compared to locally to  
14 prove our point.  
15

16 Now, I will cite the case where a  
17 worker came to me one year ago with a case of ring-  
18 worm. Now, ringworm is one of the most common ail-  
19 ments we see, and it is treated with Griseofulvin.  
20 It is an excellent drug on the market, it is safe,  
21 it has been proven and it is effective. This man  
22 came to me, and since he was an American I said  
23 that it might be more economical for him to have  
24 this drug prescribed in New York and I asked him if  
25 he would advise me of the cost of it. This man  
26 wrote me a letter on the 3rd of November, 1960:  
27  
28  
29  
30



Dear Dr. Weinstein, On my last visit if you will recall, you asked me to get you a price of the enclosed prescription. I inquired about it and I was informed that the best possible price on this would be eight cents each. I'm returning the prescription as the doctor who treated me now, advised me not to use it at the present time."

Now, that was simply a question of choice. The point I was trying to bring out was that it was 8¢.

THE CHAIRMAN: That is the New York price?

DR. WEINSTEIN: That is the New York price. This man came into me on the 20th of July, and I went to the druggist and asked him to quote me the price of this. This happens to be Griseofulvin and it is manufactured by Schering. He said there had been a tremendous drop in the price effective January of this year, 1961. This is several months after. This man came in last July. The local price was 30¢ compared to the New York price of 8¢, six months later, \$5.40 for 30 tablets, which is approximately about 18¢ or \$17 for 100, 17¢. In other words, six months later, after a tremendous drop in price it was still twice as much as in New York.

Now, I submit that this price differential can be attributed to two things. One, that the privileges of the podiatrists across



1 Canada is in such a state of confusion with regard  
2 to the various provincial and federal statutes.

3 THE CHAIRMAN: That is what is called  
4 a prescription drug?

5 DR. WEINSTEIN: Yes, that is a pres-  
6 cription drug which we podiatrists are empowered  
7 to use.

8 MR. FRAWLEY: What is the drug?

9 DR. WEINSTEIN: Griseofulvin. It is  
10 an oral antibiotic for fungus.

11 We submit there are any number of  
12 drugs which we podiatrists use, the local anaesthe-  
13 tics, any of these drugs. The differential in  
14 price, because of the advertising revenue, there  
15 is a greater use, the consumer benefits in the  
16 United States, but in this country there is a state  
17 of confusion, they don't know in which province  
18 they can ethically dispense and in which they can't  
19 and they are reluctant to advertise. Whether this  
20 has a bearing on the ultimate price or not, it is  
21 a fact.

22 THE CHAIRMAN: Some drugs, of course,  
23 may not be advertised?

24 DR. WEINSTEIN: That is true, sir.  
25 But we suggest if these drugs were to be researched  
26 as they are in the United States - in other words,  
27 a new drug comes out: we have some 3,000 members  
28 on the staffs of 1,000 recognized Class 'A'



1 hospitals and they use them in these hospitals under  
2 controlled conditions to make sure these are sound  
3 and effectual, and when they are found to be so they  
4 recommend them to the profession, and naturally that  
5 has an effect because there is a greater use of our  
6 recognized drug and the cost comes down. If the  
7 manufacturers don't have this market, obviously the  
8 price is up, and we submit that is one of the reasons  
9 and we cite this example: We don't say it is the  
10 entire issue; there must be more for the drug to  
11 be twice as much as in New York. It is the same  
12 drug, but our patients are deprived of some of  
13 these drugs. If I have to tell a patient with ring-  
14 worm of the nail that it is going to cost him a  
15 dollar a day for three to six months and it is not  
16 necessary with respect to saving his life, he is  
17 reluctant to pay that. It would be different if it  
18 was a question of a heart remedy, but when it is a  
19 question of itch, it is a question of local blisters,  
20 and particularly when they are covered, then he is  
21 reluctant to spend that. On the other hand, if  
22 the price dropped down to 8¢ a day, then that is  
23 different; I submit they would be prepared to spend  
24 that and clear it up once and for all.

25  
26  
27 In other words, we submit our patients  
28 are being denied sound, ethical treatment.

29 THE CHAIRMAN: I suppose the patients  
30 that do go to practising physicians get the drugs





1 prescribed?

2  
3 DR. WEINSTEIN: They can refuse to  
4 accept the prescription just as they do refuse to  
5 accept it from us.

6 THE CHAIRMAN: Yes, a patient may not  
7 buy a drug merely because it is prescribed, but why  
8 go to the doctor?

9 DR. WEINSTEIN: Yes, that is right.  
10 We see many of these conditions peculiar to the  
11 feet, that we are the ones to lower the price.  
12 Say there are a thousand men needing prescriptions  
13 and there are 300 physicians, that makes a big  
14 difference to the manufacturing chemist when there  
15 are 300 more men going to prescribe for foot condi-  
16 tions.

17 THE CHAIRMAN: I am just wondering how  
18 that fact would enable you to work the price of  
19 drugs down?

20 DR. WEINSTEIN: Very simply, sir. If  
21 the laws concerning the right and the use of podia-  
22 trists to use these across Canada were prescribed  
23 you will find two things will happen. First of all,  
24 the manufacturer will be more amenable to adverti-  
25 sing that drug, he will detail it better, our men  
26 will try it and the drug is accepted into practice.  
27 It is accepted into practice if, after detailed  
28 research at a research centre, it is favourably  
29 commented upon. But you know in different parts of  
30



1 the world the drug research by different groups will  
2 give you a different set of data. It may be due to  
3 climate, it may be due to interpretation of the  
4 information rendered. Then you have the individuals  
5 who are given certain drugs, go ahead and use them,  
6 give us your individual reports. Then you have the  
7 manufacturer, and I submit that the average indivi-  
8 dual who gets a new drug will do this: he will put  
9 it on the shelf and he will have an indigent patient  
10 who can't afford to buy it and he will say: "Mrs.  
11 So-and-So, I have a new drug. I want you to try  
12 it. Use it and come back in ten days". If he sees  
13 that it bears up to any degree what the manufacturers  
14 state he will start prescribing it. That is how the  
15 bulk of our drugs are accepted, and that is how they  
16 are rejected, no matter what the detail man says.  
17 In other words, it is the indigent patients by and  
18 large who serve as our proving grounds.

20 THE CHAIRMAN: I understand your point  
21 is that the drug manufacturers don't advertise to  
22 your people, the podiatrists?

23 DR. WEINSTEIN: In Canada, yes.

24  
25  
26  
27  
28  
29  
30



i/dpw

1 THE CHAIRMAN: They do advertise, from  
2 all the information we have, on quite an extensive  
3 scale to doctors.

4 DR. WEINSTEIN: That is quite true,  
5 because there is more of them, but we are trying to  
6 bring out that there are certain drugs of particular  
7 benefit to the foot health of this country not being  
8 properly reduced in price because of this factor,  
9 the laws are in confusion.

10 THE CHAIRMAN: And the manufacturers  
11 don't know whether they are permitted to advertise?

12 DR. WEINSTEIN: That is right, and we  
13 say this is based on the ignorance which exists today  
14 throughout the length and breadth of our country on  
15 the part of the practising pharmacists.

16 THE CHAIRMAN: Provincial laws deter-  
17 mine the status of the podiatrist.

18 DR. WEINSTEIN: Provincial laws in  
19 most of the states grant them the right to practise.

20 THE CHAIRMAN: States or provinces,  
21 which are you talking of?

22 DR. WEINSTEIN: Both. And on the  
23 back page of the little brochure on the comparison  
24 of pharmaceutical statutes, there is no restriction.

25 THE CHAIRMAN: And this deals also  
26 with Canadian provinces?

27 DR. WEINSTEIN: Yes, and if you take  
28 a look at the provinces in Canada, you will find  
29  
30



1 that there is quite a remarkable difference.

2 MR. FRAWLEY: What does W.C.B. mean?

3 DR. WEINSTEIN: Workmen's Compensa-  
4 tion Board. In other words, in practically all the  
5 United States they list all medication, no restric-  
6 tion whatsoever, yet you come to Canada and you  
7 find practically total ignorance. We submit that  
8 this Commission could go a long way towards redu-  
9 cing the cost to the consumer by recommending that  
10 this confusion should be eliminated.

11 THE CHAIRMAN: The list of the Canadian  
12 provinces indicates that your authority is very  
13 limited in this country.

14 DR. WEINSTEIN: The limitation is  
15 rather peculiar in this respect. The right to prac-  
16 tise is not limited. The right to use the drugs is  
17 circumscribed by failing to list the profession in  
18 the Pharmaceutical Act. On one hand the province  
19 gives, and on the other hand it takes back. On  
20 page 5, 4, 5 and 6, on page 4 we compared the  
21 amount of hours spent on teaching drugs at the  
22 University of Alberta compared to that recommended  
23 by the American Podiatry Association Council on  
24 Education. The University of Alberta devoted 198  
25 hours teaching drugs. The dentists get 90 hours.  
26 Podiatrists are supposed to get 176. Now,  
27 certainly there is no basis on scientific fact.  
28 Take the hours illustrating drug education  
29  
30



1 generally in the United States. The Medical Faculty  
2 at the University of Alberta is 198; for dentists it  
3 is 90. The Chicago College 216 hours. Illinois  
4 College 180 hours. Ohio College 192 hours. New  
5 York College 176 hours. The University of Temple,  
6 which has now been taken over by Medical Hospital,  
7 192 hours. California College 160 hours. Gentle-  
8 men, there is something wrong. Let me go one step  
9 further. I carried out personally, and this informa-  
10 tion I obtained from the office of the Alberta Dental  
11 Association, and this is on page 7, source, agenda  
12 on dental education, Canadian Dental Association,  
13 March 17th-19th, 1960. Curriculum hours, it is  
14 listed as Appendix D. These are the various acce-  
15 dited dental schools across Canada, and this is the  
16 amount of hours they give according to their calendar.  
17 Why there is a difference I don't know. Alberta 84  
18 hours, University of Toronto 68 hours, University  
19 of Montreal 120 hours. Incidentally, that is the  
20 highest of drug education across Canada for dentists.  
21 McGill University 57 hours and Dalhousie 61 hours.  
22 In other words, the highest education any dentist  
23 in Canada gets is 120 hours on drugs. The lowest  
24 in the United States is 160. The dentist can use  
25 any drug. We are circumscribed.

26  
27  
28 We say there is something wrong, and  
29 the Commission can do a great deal towards rectifi-  
30 cation of this, and the public will benefit by it.



1 The bigger the base, the lower the cost.

2 THE CHAIRMAN: Are you going to make  
3 any further comments on the brief?

4 DR. WEINSTEIN: If you have any ques-  
5 tions I can answer.

6 THE CHAIRMAN: We haven't read it.  
7 We just got it.

8 DR. WEINSTEIN: The brief was merely  
9 to point out the anomalies in the law. We attempted  
10 to point out that on the basis of education, on  
11 the basis of requirement, there is utter confusion.

12 For instance, let me give you an idea.  
13 A man in Ontario is not allowed to use a local anaes-  
14 thetic to treat a foot patient. I submit that a man  
15 with an ingrown toenail, neither you nor I would care  
16 to have him operate without freezing that toe. It  
17 is ridiculous. In Alberta, if a man has twisted  
18 his ankle, I can give him a nerve block and place it  
19 in a cast. Why am I not allowed to give him a local  
20 anaesthetic such as 292? It is certainly not based  
21 on facts. We are in a jungle here.

22 THE CHAIRMAN: We must bear in mind,  
23 of course, that our Commission is dealing with  
24 federal matters, and your authorization to practise  
25 is provincial.

26 DR. WEINSTEIN: We recognize that,  
27 but we also believe that a word of recommendation  
28 from this Commission will go far.  
29  
30





1 THE CHAIRMAN: You may be more optimi-  
2 stic than we are.

3 DR. WEINSTEIN: But we believe, if it  
4 were shown that the people will benefit on the maxi-  
5 mum service, not on the minimum, the cost comes down.  
6 These facts which I have presented to you are facts  
7 from official sources. The sources of education are  
8 there for you to check.

9 This letter, if you wish to have it  
10 on the record, you are quite welcome. I asked for  
11 the patient to sign it.

12 THE CHAIRMAN: We have had a number  
13 of instances of very substantial variations in prices  
14 of drugs purchased in different places, and even  
15 purchased in Canada, but coming from different  
16 sources, some of which are outside the country.

17 DR. WEINSTEIN: Let me give you a  
18 perfect illustration, sir. I am sure that you are  
19 acquainted with the use of the National Formulary,  
20 which is an international reference on drugs, which  
21 is a federal reference as well as provincial. On  
22 page 6 in small letters you will find six members  
23 of our profession listed as the Advisory Committee  
24 on Podiatry preparations. These men have two  
25 degrees. They are all druggists first. Having  
26 left the drug field, they have entered our profes-  
27 sion with a degree in podiatry, and now serve on  
28 the National Formulary Committee. As a result of  
29  
30



1 those people working there, the manufacturers are  
2 much more cognizant of what we can use. A perfect  
3 example is that in the March issue of this year.  
4 Here is a full-page ad endorsing a new anaesthetic,  
5 Cardocaine. This is not something new. It has  
6 been used, it is quite effective. I have used it  
7 myself, yet it has not been detailed to our men in  
8 this country. I had to write to obtain a sample,  
9 and the price here is greatly higher than that in  
10 the States. And there is something wrong when our  
11 men are not acquainted with a proven safe anaesthe-  
12 tic which they are allowed by law to use.

13  
14 THE CHAIRMAN: If they are allowed by  
15 law to use it there should be information available.

16 DR. WEINSTEIN: That is right. As  
17 you know sir, for years Novocaine and Procaine was  
18 a standard local anaesthetic until penicillin came  
19 out. When penicillin came out the manufacturers  
20 decided well, we will have to minimize its effect  
21 at the site of injection, so they provided it with  
22 Procaine. That was fine up to a point, then this  
23 is what happened. We found that certain people,  
24 due to what particular ailment they had, particu-  
25 larly with someone in the case of V.D. This lady  
26 came into me and told me she had had syphilis and  
27 been treated. I asked her if she had any reaction  
28 to penicillin with Procaine, and she said no. Her  
29 complaint when she came into me she had two big  
30



1 toes just rotten with infection. Obviously I  
2 couldn't treat her without freezing. When she told  
3 me that she didn't have sensitivity to Procaine, I  
4 used a Procaine anaesthetic. That lady developed  
5 shock and by the grace of God I got her out of it  
6 before she died in my office. Today, with all  
7 these anaesthetics being combined with antibiotics,  
8 we have to change. I wouldn't use Procaine in my  
9 office if you paid me. Now, when you take a look  
10 on TV they are doing the same thing with zylocaine.  
11 Pretty soon you are going to find people are going  
12 to react to zylocaine, so therefore I say in the  
13 interests of the profession, the public, and their  
14 safety, we have got to change. And the only way we  
15 can change is by introducing it through the journals.  
16 We have got to know it is safe. The only way you  
17 can change is by bringing it to the notice of our  
18 men.  
19

20 THE CHAIRMAN: Are there Canadian univer-  
21 sities that give degrees in podiatry?

22 DR. WEINSTEIN: It is a national dis-  
23 grace that this is the only English-speaking country  
24 without a college. There are colleges in Australia,  
25 the United States, and in England. We have a popu-  
26 lation of about 18 million, and we haven't got one.  
27 The Department of Veterans' Affairs paid approxi-  
28 mately \$6,500.00 to educate me.  
29

30 THE CHAIRMAN: Did you go to the



1 United States?

2 DR. WEINSTEIN: I had to go to the  
3 United States under my D.V.A. veterans' allowance,  
4 so did my colleague, Dr. Paran. It is a costly  
5 education, that is what we are trying to bring out.  
6 The only way we can get a college is by what we  
7 are discussing here. Have the manufacturers'  
8 support, so there is something wrong in this  
9 country when we have 18 million people and no college.  
10 D.V.A.-trained men cannot treat D.V.A. patients, yet  
11 in the United States, by law they are allowed to do  
12 that, and admitted with commissions in the armed  
13 forces. Our people are paying too high a price,  
14 that is why we are here sir, to beg your Commission's  
15 co-operation. The foot health of this country, sir,  
16 we feel is neglected.

18 MR. FRAWLEY: I have no comment,  
19 except perhaps I should note that one of Dr. Wein-  
20 stein's proposals is a far-reaching one. On page 4,  
21 that this Commission suggest that the conflict in  
22 federal and provincial legislation may readily be  
23 clarified by declaring section 22 of the Alberta  
24 Professions Act -- I take it that the reference  
25 there is to the Podiatry Professions Act probably?

27 DR. WEINSTEIN: Yes sir.



1 MR. FRAWLEY: I think that there is a  
2 place for these declarations to be made and it is  
3 not this Commission.

4 DR. WEINSTEIN: That is quite true.  
5 We accept that criticism. We knew that ahead of  
6 time. If you will look a little further on we  
7 also have another suggestion.

8 MR. FRAWLEY: I do not doubt his  
9 sincerity at all. I just thought I should comment  
10 on that.

11 THE CHAIRMAN: I think what Dr. Wein-  
12 stein is proposing is that we would suggest to the  
13 proper authorities that this might be done.

14 DR. WEINSTEIN: Yes sir. That is all  
15 we are asking.

16 THE CHAIRMAN: It may not be declared  
17 ultra vires. That is strictly a constitutional  
18 matter. Generally it ends up in the Supreme  
19 Court.

20 DR. WEINSTEIN: Yes.

21 THE CHAIRMAN: Do any of your asso-  
22 ciates wish to make any comment, Dr. Weinstein?

23 DR. WEINSTEIN: I am afraid not, sir.

24 THE CHAIRMAN: Thank you very much  
25 anyway.

26 Is there anybody else here desires  
27 to make any representation to the Commission concer-  
28 ning of the subject matters of this inquiry?  
29  
30



1 We do not expect there will be further  
2 hearings in Edmonton so if anybody is thinking of  
3 making representations, it would need to be done now,  
4 if it is going to be done orally. Subsequently we  
5 can receive written briefs but we will not be here  
6 for any further oral presentations.

7 If there is nobody else here who  
8 desire to make any representations then this will  
9 conclude the hearings in Edmonton.

10  
11  
12 --- Whereupon the proceedings adjourned until  
13 July 27th, 1961.





INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C. -- Chairman

A.S. WHITELEY, M.A.      Member of the  
Commission

PIERRE CARIGNAN, Q.C.      Member of the  
Commission

F.N. MACLEOD  
representing the Director of Investigation  
and Research

Proceedings of hearings commencing at  
10 a.m., Thursday, July 27th, 1961,  
et seq, in the City of Calgary, in the  
Province of Alberta.





pw  
1 THE CHAIRMAN: I think everybody knows  
2 for what we are here, the hearings in Calgary of the  
3 Restrictive Trade Practices Commission of an inquiry  
4 into the manufacture, distribution and sale of drugs  
5 and we wish to hear representations made by organiza-  
6 tions or people in this area while we are in the city.

8 Mr. MacLeod, have you any information  
9 you can give us as to who will be appearing and the  
10 order this morning?

11 MR. MACLEOD: I understand, sir, that  
12 the Alberta Pharmaceutical Association, that is an  
13 Association of Retail Druggists, will be presenting  
14 a brief and that F.P. Publications Limited will be  
15 presenting a brief.

16 THE CHAIRMAN: Those are the only two?

17 MR. MACLEOD: Those are the only two of  
18 which I know, sir.

19 According to the radio the labour  
20 group who had intended to submit a presentation is  
21 not making one because their parent organization is  
22 making one in Ottawa.

23 THE CHAIRMAN: For the record, we would  
24 like to know the names of those who are appearing for  
25 the parties making these representations.

26 MR. FORSYTH: For the Alberta Pharma-  
27 ceutical Association, Mr. Chairman, Mr. W.A. Howard,  
28 Q.C. and myself, G.R. Forsyth as counsel. The submis-  
29 sion will be presented by Mr. Walter Maday, President  
30



1 of the Alberta Pharmaceutical Association but also  
2 present and available to answer any questions that  
3 the Commission or any other interested parties may  
4 have is Mr. Donald Cameron, Registrar-Treasurer of  
5 the Alberta Pharmaceutical Association and Dr. M.J.  
6 Huston, Dean of the Faculty of Pharmacy at the  
7 University of Alberta, Edmonton.  
8

9 THE CHAIRMAN: I am afraid I didn't  
10 get Mr. Maday's initials.

11 MR. FORSYTH: Walter, W. Maday.

12 THE CHAIRMAN: Mr. Maday will be  
13 presenting a brief?

14 MR. FORSYTH: That is correct, sir.

15 THE CHAIRMAN: For the F.P. Publica-  
16 tions?

17 MR. ROMAIN: My name is Donald  
18 Romaine, Mr. Chairman. I will be reading our submis-  
19 sion.  
20

21 THE CHAIRMAN: Is there anybody with  
22 you, Mr. Romaine?

23 MR. ROMAIN: No sir.

24 THE CHAIRMAN: Are there any others  
25 here who wish to make any representations to the  
26 Commission so that we will know who will be having  
27 something to say and perhaps be able to judge our  
28 time better?

29 If there are no others, those two will  
30 be heard in the order in which they have been given



1 to us.

2  
3 Are there any other appearances on  
4 behalf of people who are not making representations  
5 today?

6 MR. HUME: Thank you, Mr. Chairman and  
7 honoured sirs. My name is F.R. Hume. I am appearing  
8 here this morning as counsel for the Canadian Pharma-  
9 ceutical Manufacturers' Association and I should like  
10 to add attending here in Calgary with me is Mr. H.J.  
11 Brown, who is President and General Manager of  
12 Burrows Wellcome and Company (Canada) Limited but who  
13 is here this morning in his capacity as President of  
14 the Association.

15 As Your Honours know we are making a  
16 submission at a later date but we are here this mor-  
17 ning as interested parties in the inquiry.

18  
19 MR. FRAWLEY: Mr. Chairman and members  
20 of the Commission: my name is J.J. Frawley and I am  
21 representing the Province of Alberta.

22 THE CHAIRMAN: Are there any others  
23 appearing on behalf of any interested parties who  
24 will not be making representations?

25 I will call on Mr. Maday then. Do you  
26 wish to read the brief?

27 MR. MADAY: Yes I will, Mr. Chairman.

28 THE CHAIRMAN: Make any comments you  
29 like as you proceed, of course.

30 MR. MADAY: Thank you, sir.



1  
2 MR. WALTER MADAY, called:

3 MR. MADAY: The Alberta Pharmaceutical  
4 Association presents this submission to the Restrictive  
5 Trade Practices Commission in its inquiry into  
6 the Manufacture, Distribution and Sale of Drugs in  
7 the hope that the information and views contained  
8 therein will be of assistance to this Commission.

9 The Association recognizes that the  
10 Canadian Pharmaceutical Association will be making  
11 representations to this Commission at a later date,  
12 which submission this Association will be supporting.  
13 Accordingly, the submission being presented at this  
14 time is intended to deal primarily with the practice  
15 of retail pharmacy in the Province of Alberta, and to  
16 give to this Commission the views and recommendations  
17 of the pharmacists in this Province as expressed  
18 through the Association. If, after hearing this  
19 submission, the Commission is desirous of obtaining  
20 further facts and statistics pertaining to the Province  
21 of Alberta, this Association would of course  
22 be quite prepared to obtain such information, if  
23 available, and submit such information to the Commission  
24 at a later date.

25  
26 It is proposed in this submission to  
27 deal with the following:

- 28 I. Academic requirements of pharmacists in the Province of Alberta.  
29  
30 II. Retail pharmacy practice in the





Province of Alberta.

III. The role of the pharmacist.

IV. Observations and recommendations.

I. ACADEMIC REQUIREMENTS OF PHARMACISTS IN THE  
PROVINCE OF ALBERTA

"Pharmacy is that profession which is concerned with the art and science of preparing from natural and synthetic sources suitable and convenient materials for distribution and use in the treatment and prevention of disease. It embraces a knowledge of the identification, selection, pharmacologic action, preservation, combination, analysis and standardization of drugs and medicine. It also includes their proper and safe distribution and use whether dispensed on the prescription of a licensed physician, dentist or veterinary surgeon and in those instances where it may legally be done, dispensed or sold directly to the consumer".

Joint Committee A.A.C.P. and N.A.B.P.

The legislation governing the registration of pharmacists in the Province of Alberta is contained in the Alberta Pharmaceutical Association Act, R.S.A. 1955, Chapter 232. In order to be registered as a pharmacist, or rather a pharmaceutical chemist, which is the terminology used in the Act in the Province of Alberta, the applicant must have attended and successfully completed the prescribed



1 courses of studies leading to the degree of Bachelor  
2 of Science in Pharmacy at the University of Alberta,  
3 and must, in addition, have served a twelve month  
4 period of internship. If the applicant is not a  
5 graduate of the University of Alberta, then the  
6 General Faculty Council of the University of Alberta  
7 must be satisfied that his qualifications at the time  
8 they were acquired were at least equivalent to those  
9 required for registration in the Province of Alberta  
10 at that time, and he must produce a certificate from  
11 the Registrar of the University so certifying. The  
12 Association would mention in passing that the pre-  
13 scribed course in the University of Alberta leading to  
14 the degree of Bachelor of Science in Pharmacy is  
15 presently three years, but commencing in 1963 an  
16 alternative fourth year will be offered. This is in  
17 keeping with the Association's aim of ensuring the  
18 steady flow of accredited, properly trained young men  
19 and women capable of meeting the needs of society in  
20 the best possible way. This necessitates a person  
21 contemplating a career in pharmacy being faced with  
22 an outlay of approximately \$7,500.00 in his profes-  
23 sional education in order that he may safely provide  
24 all the necessary service in drugs required by his  
25 community, coupled of course with his loss of poten-  
26 tial earning power during his University years.  
27 Admittedly the pharmacist is not unique in this  
28 respect but it is a factor which this Association  
29  
30



1 submits should not be lost sight of in the course of  
2 this Committee's investigation.

3  
4 The Alberta Act is very similar to  
5 corresponding acts in other Provinces of Canada in  
6 that it provides that only a registered pharmaceutical  
7 chemist or registered intern under the immediate per-  
8 sonal supervision of a registered pharmaceutical  
9 chemist may dispense prescriptions. It further  
10 makes it illegal for anyone to hire other than the  
11 above mentioned people to dispense.

12 II. RETAIL PHARMACY PRACTICE IN THE PROVINCE OF  
13 ALBERTA

14 At the date of this submission there  
15 are 722 practising pharmacists in the Province of  
16 Alberta, and 439 pharmacies carrying on business in  
17 this Province, or approximately one pharmacy for  
18 every 3,000 persons in the Province of Alberta.  
19 This Association does not propose to deal with the  
20 incomes of pharmacists and/or pharmacies in this  
21 Province as it is assumed that the Commission  
22 already has available to it much of this information,  
23 and it is further assumed that the submission of the  
24 Canadian Pharmaceutical Association will be dealing  
25 with this facet. It might be mentioned in passing  
26 however that the position in Alberta is in line with  
27 the picture throughout Canada.

28  
29 The Alberta Association supports any  
30 method by which the cost of drugs to the Public can



1 be lowered so long as such methods are consistent  
2 with public safety, and do not infringe upon the  
3 professional responsibility of the pharmacist and  
4 the physician in prescribing to the individual  
5 patient's needs. The suggestion has been made that  
6 the pharmacist could effect an immediate reduction  
7 in prescription prices by ordering his pharmaceuti-  
8 cals from drug manufacturers who distribute under  
9 generic names as opposed to trade names. This Asso-  
10 ciation has recently completed an analysis of pres-  
11 criptions written in Alberta which through the exi-  
12 gencies of time was necessarily somewhat limited.  
13 The intent of the survey was to establish the percen-  
14 tage of the prescriptions written for brand name pro-  
15 ducts as opposed to those written for dispensing by  
16 the generic name or requiring compounding in the  
17 pharmacy. The survey was conducted by checking the  
18 records of selected drug stores in the following  
19 centres:  
20  
21

Lethbridge	Claresholm
Edmonton	Mannville
Calgary	Red Deer
Barrhead	

22 The stores selected were taken as  
23 representative of the various types of pharmacies  
24 operating in the Province of Alberta. In the majo-  
25 rity of cases the method followed was to check every  
26 one hundredth prescription written over the past  
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28  
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1 three years noting the quantity prescribed and the  
2 prices charged. In some cases only the two hundred  
3 and fiftieth prescription over the past three years  
4 was checked. In all a total of 3,491 prescriptions  
5 were noted in this fashion and the following was the  
6 result of the survey:  
7

8 3,119 prescriptions were written for  
9 brand name products (89.34%)  
10 243 prescriptions were written using  
11 generic terminology (6.69%)  
12 129 prescriptions required compounding  
13 in the pharmacy (3.97%)

14 The average price of prescriptions checked over the  
15 three year period was \$3.15.  
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1/dpw

1 It would follow therefore that the  
2 inference that the pharmacists could immediately  
3 effect an appreciable saving by adding to their  
4 inventory a line of generic drugs is not accurate.  
5 Such a step would serve only to add greatly to the  
6 inventory of a drug store to accommodate a very  
7 small percentage of the prescriptions written in  
8 the light of present day experience. It should be  
9 mentioned in this submission as no doubt it has  
10 been dealt with in other submissions before this  
11 Commission, that where a physician prescribes a  
12 brand name the pharmacist is by law required to  
13 furnish the patient with that brand name drug and  
14 does not have any right to substitute another com-  
15 pany's brand or a generic drug of the same nature.  
16 This Association would suggest that the physician  
17 is by training and tradition charged by the public  
18 to diagnose and prescribe that product which in  
19 his professional opinion and experience will effect  
20 the desired results. The pharmacist is by training  
21 and tradition and law charged to dispense that which  
22 was ordered and when the prescription is written by  
23 the generic name, the pharmacist will dispense the  
24 product which in his professional opinion and  
25 experience will also effect the desired results.  
26 The pharmacists do not presume to tell the physicians  
27 how and in what manner they should prescribe; in  
28 fact the Association submits that the public would  
29  
30





1 serve itself ill by attempting to upset the present  
2 physician-pharmacist-patient relationship.  
3

4 Should it be the policy of physicians  
5 to prescribe by generic terminology the retail pharma-  
6 cists of Alberta would not be unhappy. They would  
7 wish it known, however, that they do not interpret  
8 this to mean that they were required to supply the  
9 cheapest. It is a fairly well recognized axiom that  
10 the cheapest is not necessarily the most economical.

11 The choice being the pharmacist's he  
12 would probably choose to dispense a product which  
13 in his experience had proven to be efficient, stable  
14 and competitive and had been manufactured by a firm  
15 whose integrity and reputation was beyond reproach.  
16 The individual pharmacist does not have the facilities  
17 necessary for testing and satisfying himself as to the  
18 standard and quality of a drug that might be available  
19 to him in Canada. Likewise, the Government of Canada  
20 cannot and does not purport to guarantee that all  
21 drugs will meet the quality and standard expected of  
22 them. In that connection reference might be made to  
23 the address of Dr. C.A. Morrell, the Director of the  
24 Food and Drug Directorate of the Department of National  
25 Health and Welfare. In his address before the Canadian  
26 Pharmaceutical Association in Saskatoon, in August of  
27 last year, Dr. Morrell stated:

28 "The Food and Drugs Act does not guaran-  
29 tee that drugs will meet the quality  
30



1  
2 standard expected of them. All we can  
3 do is correct violations wherever we  
4 find them and in certain cases to punish  
5 those who do not accept their responsi-  
6 bility".

7 It follows that the pharmacist must of  
8 necessity be forced to rely on those drugs which  
9 through experience he knows he can rely on to satisfy  
10 the requirements of safety and efficacy.

11 At this time it might be useful to  
12 this Commission to know something about the pricing  
13 habits generally followed by pharmacists in this  
14 Province. The pharmaceuticals bought for dispensing  
15 on prescription are in most instances purchased from  
16 manufacturers less a discount. The price from which  
17 the discount is allowed is known as a "suggested list  
18 price". This list price includes the 11% Federal  
19 Sales Tax. This suggested list price may be used as  
20 the selling price, but it also may be lessened or  
21 exceeded depending on the policy of the individual  
22 pharmacy. In Alberta, when the prescription is dis-  
23 pensed in the original quantity, there is usually  
24 added to the selling price, be it the suggested list  
25 price or otherwise a professional fee of \$ .75.  
26 Should a quantity less than the original be pres-  
27 cribed, the fraction of the whole is computed and a  
28 professional fee of \$1.00 is usually added. When  
29 compounding of a prescription is involved, the  
30



1 professional fee of the pharmacist is calculated by  
2 the time factor.

3  
4 This, sir, is based on a \$4.50 per hour  
5 basis.

6 It should here be mentioned that when  
7 purchases are made from the wholesale level, the  
8 margin of profit may be less, assuming that the  
9 suggested list price is accepted as the selling  
10 price.

11 The professional fee has been scored  
12 in some areas, and seems to the Association to have  
13 aroused unjustified rancor. This Association's sub-  
14 mission previously outlined the educational require-  
15 ments for a pharmacist, and pointed out the responsi-  
16 bilities which the profession demands. These  
17 professional responsibilities, as previously mentioned,  
18 are set out in The Alberta Pharmaceutical Association  
19 Act; and as well other responsibilities of a pharma-  
20 cist may be found in the Opium and Narcotic Drug  
21 Act, R.S.C., 1952, Chapter 201 as amended, and the  
22 Food and Drugs Act, S. of C. 1952-53, Chapter 38 and  
23 regulations thereto. Too often the suggestion is  
24 made that a pharmacist is more a merchandiser than a  
25 professional man. While it is true that the greater  
26 percentage of his sales volume is derived from sales  
27 of other than prescriptions, it is the dispensary  
28 and the dispensing of prescriptions which characterizes  
29 the pharmacist and establishes his place in the  
30



1 community and as a member of the health team.

2  
3 There is another school of thought in  
4 Alberta which advocates the dispensing at cost plus  
5 a professional fee. The fee most usually quoted is  
6 \$2.00. This method has not, to the Association's  
7 knowledge, had a sufficiently widespread trial to  
8 estimate its worth in this Province.

9 Prescription pricing runs the entire  
10 gamut of these various methods in Alberta, i.e.  
11 dispensing at suggested list plus a professional fee  
12 of \$ .75 or \$1.00, dispensing at list, and dispen-  
13 sing at cost plus a professional fee, or an indivi-  
14 dual store policy that is a variation of one or more  
15 of these.

16 It should be established that the  
17 professional fee of \$ .75 or \$1.00 as the case may  
18 be, forms part of a suggested professional fee  
19 schedule prepared by a select committee of the Alberta  
20 Pharmaceutical Association. The professional fee  
21 schedule was forwarded to all members of the Associ-  
22 ation and was accompanied by a letter dated July  
23 29th, 1960, over the signature of the Registrar of  
24 the Association, which letter stated in part:

25  
26 "This professional fee schedule is  
27 well and carefully thought out. It  
28 is intended to offer a guide to you  
29 as to the amount of the professional  
30 fee to be charged by you for the



1 dispensing of prescriptions. The  
2 amount to be charged for the pharma-  
3 ceuticals remains, as it always has,  
4 in your discretion".  
5

6 On the basis of the survey conducted  
7 by this Association the average price of prescrip-  
8 tions written in Alberta over the past three years  
9 was found to be the sum of \$3.15, or slightly above  
10 the national average for year 1959. The most recent  
11 figures available at this time for prescription  
12 consumption covers the year 1959 when the average  
13 Canadian citizen received approximately  $2\frac{1}{2}$  prescrip-  
14 tions per year. Assuming this figure is applicable  
15 for the three year period covered by the Association's  
16 survey in Alberta, this meant that the average  
17 Alberta citizen spent  $2.5 \times \$3.15$  or a total of \$7.88  
18 per year on prescriptions over the past three years.  
19 If we assume the average Calgary family is four in  
20 number, we find that such a family would spend the  
21 sum of \$31.52 annually on prescription drugs. On  
22 the basis of figures furnished to this Association  
23 which estimate the average family income in the city  
24 of Calgary for the year 1958 at the sum of \$4,286.00,  
25 this means that a Calgary family spends on the  
26 average about 0.735% of its yearly income on pres-  
27 cription drugs.  
28

### 29 III. ROLE OF THE PHARMACIST

30 The Association would like to briefly



1 set before this Commission what in its submission  
2 has become the role of the pharmacist in the modern  
3 community.  
4

5 While it is true that the compounding  
6 has lessened, the responsibility of the pharmacist  
7 has, if anything, increased in line with the tremen-  
8 dously large number and variety of drugs on the  
9 market today.

10 The pharmacist is advisor to the  
11 physician in matters of availability,  
12 forms of medication, dosage, unfavo-  
13 rable side effects of certain medica-  
14 tions and matters of this nature.

15 He is the health supply officer in  
16 the centre of his community.

17 He deliberately transgresses good  
18 stock control procedures by maintai-  
19 ning slow moving pharmaceuticals or  
20 other health aids, because they have  
21 been asked for on occasions.

22 He is required to keep records of  
23 purchase and sale of certain specified  
24 drugs and indicate his authority for  
25 such sale.  
26

27 He is charged with the custody of  
28 drugs and poisons and statutes dictate  
29 their method of release.

30 His services are available on an





average of ten to twelve hours daily  
by virtue of his place of business  
being open and practically speaking  
his service is available to the public  
twenty-four hours a day.

The pharmacist's professional responsi-  
bility as it relates to the filling of a single  
prescription can be broken down into eight well-  
defined steps:

1. Verification of dose, directions,  
signature and patient.
2. The actual dispensing.
3. Packaging the prescription.
4. Labelling in accordance with the  
physician's directions.
5. Entries made to comply with  
various statutes governing the  
profession of pharmacy as well as  
those records usually kept by the  
pharmacist to facilitate prescrip-  
tion refills for the patient.
6. Pricing the prescription.
7. Explaining the directions to the  
patient so that they will be  
clearly understood.
8. Reassurance to the patient both as  
to the efficacy of the prescrip-  
tion and the inviolability of his



confidence.

Throughout this process all elements of the prescription are checked at least three times; when the ingredients are collected; during the actual dispensing; and when the ingredients are replaced on the shelf.

The end product of the pharmacist's labor is a specific remedy for a specific disorder for a specified person. It cannot be resold and in fact might, and probably could, be dangerous to another person. In this regard this Association would comment that too often comparison is made between the operation of a pharmacy and operation of other retail outlets. While there may be some value in such comparison, the Association would suggest that too much value cannot be placed on such comparison in light of the fact that the pharmacist is, by legislation and professional ethics, quite properly restrained from engaging in the normal trade practices of retail merchandising.

#### IV. OBSERVATIONS AND RECOMMENDATIONS

1. It is the submission of this Association that in light of the information revealed by the survey, the immediate stocking of generic drugs by pharmacists would not materially reduce the cost of prescriptions in this Province under present circumstances.

2. It is the submission of this



1 Association that more widespread use of generic drugs  
2 with the possible reduction in prescription price to  
3 the public must be preceded by

4 a. more stringent regulations rela-  
5 tive to the manufacture, purity,  
6 availability from the dosage form,  
7 and stability of prescription  
8 drugs,

9 b. enlargement of the staff of the  
10 Food and Drug Directorate to the  
11 degree necessary to ensure enforce-  
12 ment of these regulations.

13 3. It is the submission of this Asso-  
14 ciation that the sales tax of 11% presently imposed  
15 on the majority of drugs in Canada should be repealed,  
16 and that such repeal would lead to an immediate reduc-  
17 tion in the price of drugs to the Canadian public.

18 This Association would like to express  
19 its appreciation to the Commission for this opportu-  
20 nity of presenting its views, and hopes that the  
21 submission of this Association will be of assistance  
22 to the Commission in its deliberations.

23 All of which is respectfully submitted.

24 THE CHAIRMAN: Thank you, Mr. Maday.

25 Do you wish to make any comments at this point on the  
26 reading of the brief?

27 MR. MADAY: No thank you, Mr. Chairman.

28 Perhaps I can answer some questions.



1 THE CHAIRMAN: I think there will be  
2 a few questions. The first one, perhaps you could  
3 clarify that the definition of pharmacy at the top  
4 of page 2. First of all it is stated it is the Joint  
5 Committee A.A.C.P. and N.A.B.P. Could you give us  
6 the full names.  
7

8 MR. MADAY: It is the American Associa-  
9 tion of Colleges of Pharmacy and the National Associa-  
10 tion of Boards of Pharmacy.

11 THE CHAIRMAN: Is this the definition  
12 originating with them or taken from some other autho-  
13 rity and adopted by them?

14 MR. CAMERON: I think it was designed  
15 by them using other authorities. It is their defini-  
16 tion.

17 THE CHAIRMAN: It is their definition.  
18 At the bottom of page 4 I note the percentage of  
19 prescriptions requiring actual compounding in the  
20 pharmacy is slightly under 4%. This is rather less  
21 than I thought to be the case. Yet in Alberta you  
22 progress further along the line?

23 MR. MADAY: No sir, I don't think that  
24 is so. As you realise these were taken from pres-  
25 criptions, every 100 or every 250 and we could very  
26 easily have taken others. We tried to give some  
27 stores, small stores and larger prescription specialty  
28 shops being apothecaries. It might easily be a  
29 dermatologist. Should we have taken a pharmacy in  
30



1 which there is a skin specialist we would have found  
2 the figures much higher. On the overall by choosing  
3 outlying stores, stores in shopping centres and  
4 various types of localities, this has been our  
5 experience.

6  
7 THE CHAIRMAN: From the statement in  
8 the brief I notice you have taken them from all the  
9 large centres with the exception of, possibly, Medi-  
10 cine Hat and a few smaller ones.

11 MR. MADAY: I could give you a break-  
12 down.

13 THE CHAIRMAN: The statement is they  
14 are selected as representative of the various types  
15 of pharmacies operating in Alberta. Perhaps you  
16 might outline what the type of pharmacies were that  
17 were covered.

18  
19 MR. MADAY: First I can answer that in  
20 Lethbridge we covered four stores, a downtown store,  
21 shopping centre and outlying store.

22 THE CHAIRMAN: Downtown, shopping  
23 centre and the sort of suburban store?

24 MR. MADAY: That is right. In Edmonton  
25 there were 15 stores.

26 THE CHAIRMAN: In similar categories?

27 MR. MADAY: Widespread through the  
28 various localities. In Calgary there were 14. In  
29 Barrhead there were two.

30 THE CHAIRMAN: How big is Barrhead?



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MR. MADAY: About 1,500, sir.

THE CHAIRMAN: 1,500 and there are two stores?

MR. MADAY: Yes sir.

THE CHAIRMAN: Rather more than the average in the Province?

MR. MADAY: Yes, they would rely on the surrounding communities.

THE CHAIRMAN: They would draw from quite a distance around?

MR. MADAY: Claresholm was also two stores. Mannville, one and Red Deer, two.

THE CHAIRMAN: Two in Red Deer?

MR. MADAY: Yes. There are five stores in Red Deer.

THE CHAIRMAN: These would include one-man stores and also stores with two, three, four and five pharmacists?

MR. MADAY: That is right.

THE CHAIRMAN: And stores which have a number of other clerks who are not pharmacists?

MR. MADAY: That is right.

THE CHAIRMAN: General cross-section of the various kinds of pharmacists. On page 5 we have the beginning of your presentation with regard to generic names. The Government of Alberta made a suggestion to the Commission in Edmonton and I noticed a statement by the Minister in this morning's





1 paper that the Government may proceed with this  
2 suggestion on its own. The suggestion is that the  
3 pharmacists should be given the power, right to fill  
4 a prescription, if the brand name is indicated, with  
5 a generic drug unless the physician indicates he  
6 wishes it filled only by that brand name drug. I would  
7 like to get the views of your Association if you  
8 are able to give them, on a proposal of that kind?

9  
10 MR. MADAY: Well, sir, we feel if this  
11 could come about and the law be uniform for all  
12 facets of pharmacy, this is, of course, good, but  
13 if it will mean hospital pharmacists can do a cer-  
14 tain thing and retail pharmacists cannot, it is very  
15 unfair, sir.

16  
17 I don't know exactly what Dr. Ross had  
18 in mind. I do know that in the Hospital Act of  
19 Alberta the pharmacy therapeutic - in hospitals over  
20 180 beds can decide which drugs are proper or can  
21 be used in the treatment of the patient. In hospitals  
22 of 180 beds and under there is a joint Pharmacy,  
23 Therapeutic Committee which was established by the  
24 Government and it is supervised or under the juris-  
25 diction of the Alberta Medical Association of College  
26 of Physicians and the Association of Hospitals of  
27 Alberta. They have set up a committee, a joint  
28 committee and they supervise the drug costs and  
29 the dispensing habits in hospitals less than 180  
30 beds capacity. The thought that the Joint Committee



1 and most therapeutic committees in hospitals have,  
2 that is to refer to a product by a generic name and  
3 that is to decrease the duplication of products on  
4 the shelf and reduces materially the cost of the  
5 product as you can buy in larger quantity and of  
6 course have a very good basis on which to submit  
7 tenders or to ask for tenders. I imagine that is  
8 what Dr. Ross had in mind.

9  
10 THE CHAIRMAN: There is one other  
11 suggestion that has been made to us. We haven't  
12 had an opportunity of considering it at all up to  
13 the present time. The suggestion is that trade  
14 names - that is the development of further trade  
15 names be stopped and something like this would be  
16 the case, where a manufacturer devises a new drug,  
17 a process for which he may obtain a patent, he would  
18 be required to use in describing that drug on the  
19 label for the bottle or box, the generic name and  
20 state it was made by such-and-such a company, the  
21 manufacturer had such-and-such a generic name drug  
22 and if it was made by several manufacturers with a  
23 slightly different process instead of having a  
24 different trade name it would just have the generic  
25 name and the name of the manufacturer on it. I  
26 wonder if that has come to your attention and if  
27 so can you give us any views of your Association?

28  
29 MR. MADAY: Of course the generic name  
30 now does appear on the brand name product.



1 THE CHAIRMAN: But the trade name is  
2 what attracts the attention?  
3

4 MR. MADAY: Predominant, yes. I guess  
5 they want to get the benefit of it. That is true.  
6 We have had nothing on this. We have nothing.

7 THE CHAIRMAN: I thought perhaps it  
8 might not have come to your attention but I thought  
9 I would inquire. I take it from your submission  
10 your Association has no objection to the use of  
11 generic name drugs if you can be sure that they are  
12 high quality and equal potency with drugs made by  
13 established companies using trade names?

14 MR. MADAY: That is right. It is of  
15 course difficult for individual pharmacists to  
16 establish themselves the product is good. He cannot  
17 travel east where the manufacture is carried out or  
18 where the distribution is carried out and inspect  
19 the plants. It is an awful outlay. We, as an  
20 Association, haven't guided pharmacists as to which  
21 products are good and which are not. It could well  
22 be that once a firm is known to be reliable then  
23 pharmacists will be very welcome to accept that as  
24 a known fact and when he dispenses he would know he  
25 would not be liable himself for giving out improper  
26 or inferior drugs.

27  
28 THE CHAIRMAN: You are a practising  
29 pharmacist yourself, are you?

30 MR. MADAY: Yes.



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THE CHAIRMAN: Where is your store?

MR. MADAY: I own a store and I am also Director of Pharmaceutical Services at the University of Alberta Hospital.

THE CHAIRMAN: Your store is in Edmonton?

MR. MADAY: That is right.

THE CHAIRMAN: I was wondering if you could tell us either from your own experience or from your knowledge of the pharmacists in the Province, as represented by your Association, whether you have found that generic name drugs are generally less reliable than drugs purchased under trade names?

MR. MADAY: No, we haven't, sir.

THE CHAIRMAN: You haven't?

MR. MADAY: We haven't found that because we haven't carried out any extensive tests on them.

THE CHAIRMAN: I was wondering if your experience is such to indicate you might draw some conclusions.

MR. MADAY: Those who have reached them, sir, I think have just done visual examinations of the products. I believe they haven't been able to test whether they are of the potency, it would be a hard question to answer.

THE CHAIRMAN: You really are not in a position to answer that question. From your



1 statement, top of page 7, when purchases are made  
2 on the wholesale level a margin of profit may be  
3 less - I assume you don't want that interpreted to  
4 mean it will be less, as I understand the whole-  
5 salers get an additional discount?

6 MR. MADAY: Yes sir.

7 THE CHAIRMAN: In some instances, if  
8 not all, that will result in the wholesaler giving  
9 the retailer about the same price as he would buy  
10 from the manufacturer, but in some cases it is a  
11 higher price?

12 MR. MADAY: That is correct.

13 THE CHAIRMAN: At the bottom of page  
14 7 and the top of page 8 you refer to the various  
15 methods of pricing. There are several different  
16 methods outlined there. The Commission is interested  
17 in seeing a variety of pricing methods, but what we  
18 really wish to know is what is the practice of  
19 pharmacists generally in this Province? As far as  
20 you can tell do they normally retail at the suggested  
21 list price plus their professional fee? Is that what  
22 is done by the great majority of them?

23 MR. MADAY: I would say the majority  
24 do follow that practice.

25 THE CHAIRMAN: Would you say the great  
26 majority do, or can you say?

27 MR. MADAY: I would say it is a greater  
28 majority that would follow the price list.  
29  
30



1 THE CHAIRMAN: One other little question,  
2 at the bottom of page 8 - I guess on the bottom half  
3 of page 8 - it refers to the average cost per family  
4 of prescriptions over the year.. It works out at  
5 \$7.88 per year on prescriptions over the past three  
6 years per person, and per family it is \$31.52 on  
7 prescription drugs. That gives you the average per  
8 family. I suppose you haven't any figures of the  
9 percentage of families that would be using prescrip-  
10 tion drugs in any one year?

12 MR. MADAY: No sir, we haven't esta-  
13 blished that.

14 THE CHAIRMAN: What really affects the  
15 individual family is how much that family pays?

16 MR. MADAY: Right.

17 THE CHAIRMAN: If 10 or 15% of families  
18 use prescription drugs in one year then they actually  
19 might pay 6 or 7 times what you have shown here and  
20 that may be much more serious.

21 MR. MADAY: This is an average.

22 THE CHAIRMAN: You haven't any informa-  
23 tion on that topic?

24 MR. MADAY: No, we haven't.  
25  
26  
27  
28  
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1 THE CHAIRMAN: This is not of any  
2 great importance but at the bottom of page 5 where  
3 you are listing the pharmacist's professional respon-  
4 sibility, where you set out all the things that the  
5 druggist will do in some instances some of these  
6 items are not of very great weight, I take it. For  
7 instance, in the actual dispensing and packaging of  
8 items. That would be very small where you take a  
9 bottle off the shelf that is already filled with  
10 the pills that are going to be handed out to the  
11 patient. Of course, there is the labelling to be  
12 done and you have to verify the prescriptions and  
13 so on.  
14

15 I wonder also with regard to item 8 on  
16 page 10: "Reassurance to the patient both as to the  
17 efficacy of the prescription and the inviolability  
18 of his confidence". The second part I can understand  
19 quite easily but I am wondering how far the pharma-  
20 cist can go in discussing the efficacy of the pres-  
21 cription with the patient? Is that not the physician's  
22 job?  
23

24 MR. MADAY: Yes, it is but we point  
25 out that fact that the patient goes to the physician  
26 and then comes back to the druggist to get the pres-  
27 cription. He asks the pharmacist "Will this really  
28 cure me?" In many cases the pharmacist has to very  
29 diplomatically handle the situation and assure him  
30 that this is the right drug. It is a psychological



1 point.

2  
3 THE CHAIRMAN: I am familiar with what  
4 the druggist tells us. I am just wondering how far  
5 you can go in that when you state "He must reassure  
6 the patient as to the efficacy of the prescription".  
7 About all he can say is "It has been used in other  
8 cases and it seems to be satisfactory and the doctor  
9 has prescribed it".

10 Then that goes back to page 9 where  
11 you say "The pharmacist is advisor to the physician  
12 in matters of availability, forms of medication,  
13 dosage, unfavourable side effects of certain medica-  
14 tions and matters of this nature".

15 MR. MADAY: Well, automatically the  
16 pharmacist gets a prescription and you might say an  
17 array of red lights start flashing in his mind.  
18 "What about the Food and Drug Act?" "What about the  
19 Narcotics Act?" "What about poison?"

20  
21 It is mental on his part. The training  
22 points it out to him.

23 MR. CARIGNAN: Mr. Maday, on page 3  
24 you state the Alberta Act is very similar to corres-  
25 ponding Acts in other provinces of Canada.

26 Now, it is stated in the document that  
27 has been prepared by the Director that under the  
28 laws of Ontario no corporation may operate a drug-  
29 store - and I am here quoting - unless the majority  
30 of the directors are from pharmaceutical chemists



1 and unless the majority of each class of shares is  
2 owned by and registered in the name of pharmaceutical  
3 chemists.  
4

5 My question is the following: are  
6 restrictions like this put on corporations under  
7 the laws of Alberta?

8 MR. MADAY: No, they are not, sir.

9 MR. CARIGNAN: Thank you.

10 MR. WHITELEY: On page 2 of the brief  
11 at the foot you state that in the training of the  
12 druggist an alternative fourth year will be offered.  
13 What do you mean by "an alternative"?

14 MR. MADAY: May I turn that question  
15 over to Dr. Huston?

16 DR. HUSTON: The position sir, I  
17 think the term should be "optional". The third year  
18 B.Sc. will continue to be the minimum for a licence  
19 in the Province for the foreseeable future but a  
20 student may elect, after completing the third year,  
21 to go on to a fourth year of specialization after  
22 which he will get a degree with honours in pharmacy  
23 or with a major in a specialty.  
24

25 THE CHAIRMAN: You are Dr. Huston?

26 DR. HUSTON: Yes, that is right, sir.

27 The specialties are a specialist in  
28 retail pharmacy or hospital pharmacy or in pharma-  
29 ceutical science; the latter being preparation for  
30 graduate work.



1 MR. WHITELEY: Would he already have  
2 had his degree by that time?

3 DR. HUSTON: He may have taken the  
4 third year degree, yes sir. He may elect to go on  
5 to the fourth year or he may elect to continue on  
6 to the fourth year without taking the third year  
7 degree. This is something like an honours programme  
8 at the University.

9 MR. WHITELEY: He doesn't get a diffe-  
10 rent degree on the completion of that?

11 DR. HUSTON: Yes, the same Bacca  
12 Laureate degree. The degree he gets reads diffe-  
13 rently. The first degree with the B.Sc. in science  
14 but the fourth year degree would be a degree in  
15 pharmacy with honours in retail pharmacy or honours  
16 in hospital pharmacy or with honours in pharmaceu-  
17 tical science. If he doesn't have the honours  
18 level then the degree would be "with major in".

19 MR. WHITELEY: Mr. Maday, on page 9  
20 in outlining your responsibilities of the pharma-  
21 cist, in the first group you have "The pharmacist  
22 is an advisor to the physician on matters of dosage  
23 and unfavourable side effects --". What sources of  
24 information would the druggist use to advise the  
25 doctor on these points?

26 MR. MADAY: We, of course, use various  
27 texts, recognized texts, the Alberta Pharmacopoeia  
28 and the United States Pharmacopoeia. We then also



1 have these encyclopedias, compilation of products  
2 by various companies.

3 We also have the information supplied  
4 by the manufacturer of these products. We also refer  
5 to articles that have appeared in the medical journals,  
6 the various types of medical journals, the American,  
7 the Canadian and the English Lancet.

8 MR. WHITELEY: Does the druggist have  
9 any difficulty in keeping up with this flow of infor-  
10 mation?

11 MR. MADAY: I imagine he has quite a  
12 bit of difficulty. It usually reaches the retail man  
13 in the form of a summary and the osteo-pharmacist,  
14 the pharmacist devotes his time to extra-curricular  
15 reading.

16 MR. WHITELEY: Is the druggist capable of  
17 appraising the significance of the information  
18 supplied to him by the manufacturer?

19 MR. MADAY: He is able to express an  
20 opinion on various opinions.

21 MR. WHITELEY: I was thinking of these  
22 unfavourable side effects.

23 MR. MADAY: Yes. He can say "Well,  
24 the indications usually are this will do so-and-so"  
25 or "It has been stated in the Lancet so-and-so".

26 MR. WHITELEY: Is he in a position to  
27 sort of appraise the standing of the person who  
28 made the study and his expressed opinion?  
29  
30



1 MR. MADAY: No, I don't think he is,  
2 sir but he will rely on, say, the status of the  
3 American or Canadian medical book. He will use them  
4 presumably and the editor will choose with discretion  
5 as to what appears.  
6

7 There is also an applied therapeutic  
8 issue available and many of the retail pharmacists  
9 have subscribed to that and it is very excellent.  
10 It is made by renowned medical men in Canada.

11 MR. WHITELEY: How would the druggist  
12 index all this information so he could readily find  
13 it when he wanted it?

14 MR. MADAY: Usually by the product,  
15 by the brand name and alphabetically and also he may -  
16 and in a hospital pharmacy, they carry a large auto-  
17 biography of articles. They would have many articles  
18 and opinions compiled, whether they are antispasmodic  
19 or antibiotics or what the effect is and such.  
20

21 THE CHAIRMAN: Mr. Macleod, have you  
22 some questions for Mr. Maday?

23 MR. MACLEOD: Yes sir.

24 MR. FRAWLEY: I have some questions,  
25 Mr. Chairman. Mr. MacLeod suggested I might examine  
26 first.

27 I wonder if it would be convenient  
28 for the witness to move forward because I would be  
29 turning my back to the Commission.

30 MR. HUME: Mr. Chairman, before my





1 friend, Mr. Frawley, starts, I recall the Commission  
2 made a ruling in Ottawa that the evidence taken by  
3 the Commission was to be under oath.  
4

5 For reasons which are known to the  
6 Commission I have not been able to be here but I  
7 noticed in the Edmonton hearings this has not been  
8 done. Perhaps this is a credit to the Province in  
9 which we find ourselves. I wondered whether it was  
10 an oversight or whether we are going to assume that  
11 the witnesses are men of good will and the evidence  
12 will not be taken under oath.

13 THE CHAIRMAN: Actually we have come  
14 to the conclusion a very large proportion of what  
15 we are getting is opinion and there would be ~~no~~  
16 advantage in putting a person under oath.

17 MR. HUME: So that will be the ruling.

18 THE CHAIRMAN: I think we expect to  
19 proceed on this basis.  
20

21 I think we feel that the evidence we  
22 are getting, even where it is factual, is as reliable  
23 as it could be under oath. We feel that they are  
24 telling us what they believe to be the facts.

25 MR. FRAWLEY: Mr. Maday, I, as I indi-  
26 cated, act for the Province of Alberta. I want to  
27 assure you at the very beginning that my Province  
28 has the highest appreciation for the profession of  
29 pharmacy and I know you yourself are associated with  
30 the University of Alberta.



1 I do want to ask you a few questions  
2 about your brief and then I have a few other ques-  
3 tions of a general character.  
4

5 Looking at the definition you have put  
6 at the top of your brief, I observe what perhaps is  
7 the key sentence: "Pharmacy is that profession which  
8 is concerned with the art and science of preparing  
9 from natural and synthetic sources suitable and  
10 convenient materials for distribution and use in the  
11 treatment and prevention of disease".

12 First I want to say without any depre-  
13 cation at all, I observed in Alberta your own analysis  
14 indicated that 89.34% of prescriptions were written  
15 for brand name products which would go into the  
16 retail drugstore in prepared forms.

17 MR. MADAY: Yes.

18 MR. FRAWLEY: So there wouldn't be  
19 any compounding of those 3,119 prescriptions which  
20 are listed at the bottom of page 4?

21 MR. MADAY: That is right.

22 MR. FRAWLEY: Dealing with your analysis,  
23 I think you are to be complimented for having under-  
24 taken that analysis, but looking at the 100 prescrip-  
25 tion check, that reminds my friend, Mr. Hume, and  
26 myself the way in which the Board of Transport  
27 Commissioners analyses the way bills.

28 I find that you have indicated that  
29 89.34% of the prescriptions were written for brand  
30



1 name products. Now, can you give us the average  
2 price for that percentage of the prescriptions?

3 MR. MADAY: It could be done, sir. It  
4 has not been calculated on that basis. We have the  
5 survey at our hands and we can still break that down.  
6

7 MR. FRAWLEY: The \$3.15 was the average  
8 price of all of these 100 prescriptions?

9 MR. MADAY: That is right.

10 MR. FRAWLEY: Would it be safe to ven-  
11 ture an estimate that for the 3,119 brand name pro-  
12 ducts, the average price would be higher?

13 MR. MADAY: I couldn't answer that,  
14 sir.

15 MR. FRAWLEY: Perhaps I can leave it  
16 this way that the information either it may be given  
17 or it can be obtained and supplied to the Commission?

18 MR. MADAY: Yes.

19 MR. FRAWLEY: I must not be asking  
20 things for the Commission but I do want to be sure.  
21 I would be interested in having this if it is not a  
22 great deal of research on your part. I do not mean  
23 now. I mean by mail, to know just what the average  
24 price of a drug is when they are broken down into  
25 the three classes.  
26

27 When you speak on page 5 that the  
28 adding of generic-named drugs would only be an extra  
29 expense and a considerable one to the pharmacist as  
30 things are at present, you mean that the physician



1 must prescribe by the generic name?

2 MR. MADAY: That is right.

3 MR. FRAWLEY: Unless the physician  
4 prescribes by the generic name nothing at all will  
5 ever be accomplished in finding out even if the  
6 use of generic name drugs will be an advantage price-  
7 wise to the consumers?  
8

9 MR. MADAY: That is right.

10 MR. FRAWLEY: Now, you do say, very  
11 properly, and I will go at once to the bottom of  
12 page 10, when you say that "widespread use of the  
13 generic drugs with the possible reduction in pres-  
14 cription price to the public must be preceded by  
15 more stringent regulations relative to the manufac-  
16 ture, purity, availability from the dosage form, and  
17 stability of prescription drugs".  
18

19 Would you not agree with me, Mr. Maday,  
20 that it is not at all too much to expect from the  
21 Food and Drug Directorate in the Federal Department  
22 when you consider the care that they take in the  
23 inspection and branding of food products?

24 MR. MADAY: The way it has been in the  
25 past I would say that we could not rely on it. What  
26 is intended is - I think ---

27 MR. FRAWLEY: That is a very fair way  
28 of putting it. You say at the moment and as a matter  
29 of fact you quoted from Dr. Morrell who indicates  
30 that the Food and Drug Act does not guarantee that



1 the drugs will meet the quality and standards expected  
2 of them.

3  
4 I put it to you, Mr. Maday, that when  
5 you find on a tin of canned peaches the words "Canada  
6 approved, fancy" that that can of peaches must and  
7 does live up to certain standards laid down by some  
8 Federal Government of Canada Department?

9 MR. MADAY: Yes.

10 MR. FRAWLEY: I say it is not at all  
11 too much to expect that we should have the same and  
12 we can expect the same assurance will be forthcoming  
13 from the Federal Department if it is going to help  
14 in this problem, as some people think it is a problem,  
15 of the allegedly high cost of drugs.

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MR. MADAY: It would be good.

MR. FRAWLEY: And again on page 10, when you say that the immediate stocking of generic drugs by pharmacists would not materially reduce the cost of prescriptions in this Province under present circumstances, and I take it what you are referring there when you say present circumstances is the fact that by and large physicians in this Province prescribe brand names?

MR. MADAY: That is correct sir.

MR. FRAWLEY: Now, passing from your submission, Mr. Maday, I would like to ask you about some things that have given me a little bit of concern. In Ottawa Dr. Nathan Schechter, who is the Chairman of the pharmacological section of the Ottawa Civic Hospital, said this at page 245: "In the case of vitamin compounds, iron compounds and various stomach gastric remedies no prescription strictly speaking is necessary, but some of the so-called ethical pharmaceutical companies will not allow a patient to buy over the counter, and prescriptions are necessary in those cases". Then again he says: "I don't really know just what the situation would be if a patient were given the name of some of these vitamins or iron preparations and told to go to the drugstore and ask the pharmacist for it. I don't know what the reaction would be". You are, I say, in a very excellent position to give the





1 Commission your views on that. First of all, is  
2 what Dr. Schechter is saying something that you know  
3 of from your own knowledge?

4 MR. MADAY: No, I don't. The Food  
5 and Drug Act specifies what can be sold to a patient  
6 without a prescription, and this is the only thing  
7 that governs the manufacturer. The manufacturer  
8 cannot come to us and say that this product you will  
9 retain for yourself. It is the Food and Drug Act  
10 that tells us.

11 MR. FRAWLEY: We know that the Food  
12 and Drug Act indicates those drugs which must not  
13 be dispensed except on prescription. Presumably  
14 everything else can be sold over the counter without  
15 a prescription?

16 MR. MADAY: That is correct.

17 MR. FRAWLEY: What Dr. Schechter is  
18 saying though, is that some of those drugs not in  
19 Schedule F, not limited to dispensing by prescrip-  
20 tion, that for some reason you cannot buy those over  
21 the counter and must present a prescription, and  
22 that comes from the manufacturer. Do you know of  
23 that?

24 MR. MADAY: No I don't. I think it  
25 is the pharmacist's professional knowledge that  
26 prohibits the sale of certain items. I refer back  
27 to some of these non-barbiturate analogues for  
28 inducing sleep. They were not on the schedule. I  
29  
30



1  
2 can say that well in the 90 to 95% of the pharmacists  
3 never sold them. They felt they were unsafe.

4 THE CHAIRMAN: Except with a prescrip-  
5 tion?

6 MR. MADAY: That is right. In other  
7 words, the individual patient should not and did not  
8 have the right to ask for it.

9 MR. FRAWLEY: Coming back to what Dr.  
10 Schechter is talking about, iron compounds, vitamin  
11 compounds and various stomach gastric remedies, do  
12 you know of the practice whereby the directions are  
13 given to you from the manufacturer that you must not  
14 sell this except by prescription?

15 MR. MADAY: No.

16 MR. FRAWLEY: In other words, we don't  
17 have that experience in this Province as far as you  
18 know?

19 MR. MADAY: Our experience in this  
20 Province should be the same as throughout the whole  
21 of Canada. This I don't follow him on.

22 MR. FRAWLEY: That would result in a  
23 patient who went in and simply had the name of a  
24 drug on a slip of paper in his pocket, and asked for  
25 it, getting the drug without prescription fee, the  
26 professional fee?

27 MR. MADAY: That is right.

28 MR. FRAWLEY: And if my friend Mr.  
29 Hume came in with a doctor's prescription for exactly  
30



1 the same thing, he would pay what I paid, plus a  
2 prescription fee, and I suggest there is something  
3 wrong.  
4

5 THE CHAIRMAN: What do the druggists  
6 in Alberta do with regard to these specific drugs  
7 that Mr. Frawley has been asking about? Do you  
8 sell them over the counter, or only on prescription?

9 MR. MADAY: The majority only on pres-  
10 cription.

11 THE CHAIRMAN: That is entirely a  
12 matter of the individual pharmacist's own decision?

13 MR. MADAY: Of his professional deci-  
14 sion, yes.

15 THE CHAIRMAN: There is no decision  
16 from the manufacturing company?

17 MR. MADAY: I wonder if we are not --  
18 this is where the manufacturer must put on his label:  
19 "For therapeutic use only".  
20

21 MR. FRAWLEY: He didn't say that. I  
22 am very glad that the Chairman asked that further  
23 question, so let us just examine it a little more.  
24 Do I understand that notwithstanding the fact that  
25 the Food and Drug Act, in Schedule F, indicates  
26 those drugs which must not be sold except by pres-  
27 cription, that there is a discretion somewhere, or  
28 thought to be a discretion, whereby the druggist  
29 will say notwithstanding the terms of the Food and  
30 Drug Act, I will not sell that except by prescription?



1  
2 MR. MADAY: That is right.

3 MR. FRAWLEY: And if I went in and  
4 was told by my doctor go and get some XYZ, and went  
5 in with nothing except that direction in writing from  
6 my physician, you would not give it to me?

7 MR. MADAY: That is right.

8 MR. FRAWLEY: I would have to go to  
9 the physician, pay his consultation fee, obtain the  
10 prescription, come into the drugstore, and pay your  
11 professional fee, although he had simply telephoned  
12 me or met me on the street and suggested I buy some  
13 so-and-so?

14 MR. MADAY: Not exactly. I think in  
15 my conversation with you I would have found out that  
16 you had been advised by your doctor, and once that  
17 is established, that there is some authority, I  
18 would probably concur and sell it without prescrip-  
19 tion.  
20

21 MR. FRAWLEY: I have a brother in  
22 California who is a doctor. Suppose he said to me:  
23 "Get so-and-so made by Upjohn", would that be enough?

24 MR. MADAY: No, I would not know whether  
25 you had a brother in California and whether he was  
26 qualified in this Province.

27 MR. FRAWLEY: Well, that explains it.  
28 That certainly makes it more expensive to obtain  
29 certain types of non-prescription drugs, having in  
30 mind the prohibitions in the Food and Drug Act, than



1 it would be if you didn't include this prescription  
2 requirement?

3 MR. MADAY: I don't feel that is quite  
4 right. I think that the drug cost remains the same.  
5 It is just for my fee and responsibility of dispen-  
6 sing that I make a 75¢ charge.

7 MR. FRAWLEY: You are overlooking that  
8 I would have to consult a physician, pay a consultation  
9 fee to the physician perhaps of \$10.00, and then a  
10 one-dollar or maybe two-dollar in the drugstore, to  
11 obtain something on which the Food and Drug Act does  
12 not put any prohibition?

13 MR. MADAY: Well, all I can say sir,  
14 is that experience has shown that with these non-  
15 barbiturates, the pharmacist was correct, and the  
16 Food and Drug Act didn't come in quick enough, there-  
17 fore it was an expense to the public for the benefit  
18 of the public and the welfare of the patient.

19 MR. FRAWLEY: In other words, you are  
20 just a little bit ahead of the Food and Drug Act,  
21 and it had to be amended this year to take care of  
22 the dispensing of goof-balls, and there will be  
23 amendments made from time to time, and you say you  
24 have already, I say this inoffensively, in a sense  
25 written something into Schedule F which is not  
26 there?

27 MR. MADAY: It could be interpreted  
28 that way.  
29  
30



1 DR. HUSTON: Mr. Chairman, if I may  
2 interject here please. The implication seems to be  
3 that the pharmacist is doing this for some nefarious  
4 purpose. This is not so. It is only for the protec-  
5 tion of the public.  
6

7 THE CHAIRMAN: I think that is perfectly  
8 clear from the examination. There was no inference,  
9 I think, in either the questions or the answers that  
10 there is anything wrong about it.

11 MR. FRAWLEY: No, nothing nefarious at  
12 all. This is in a sense a price investigation, and I  
13 think everything we can get at is of some concern to  
14 the Commission. At the Edmonton sitting, the Canadian  
15 Mental Health Association told about two instances  
16 where they found it is difficult to obtain some of  
17 these post-hospital drugs, which I am sure are well-  
18 known to you, and I would like to ask you about them.  
19 The first is Schering's Trilafon. This is what was  
20 said, because you probably have not seen this brief,  
21 or by some good chance, have you seen it?  
22

23 MR. MADAY: No.

24 MR. FRAWLEY: Reading from the brief:  
25 "Another White Cross contact while steadily employed  
26 at a small salary had the opportunity to write a  
27 qualifying examination for a better position with a  
28 higher salary. Preparing for the examination he was  
29 overcome by anxiety and emotional depression. He  
30 was put in touch with a psychiatrist who prescribed





1 Trilafon. The psychiatrist advised us that if he  
2 did not secure this medication immediately, further  
3 hospitalization would be necessary. Our contact did  
4 not have enough money on hand to purchase ten days'  
5 medication. Fortunately we were able to secure medi-  
6 cation with the aid of another agency and the patient  
7 rallied well and was able to take his examination".

8  
9 With that background, I would like you  
10 to look at page 194 of the Green Book. Page 194 sets  
11 out the Director's story of Schering's Trilafon. If  
12 you will take it from me that the Trilafon was 8 milli-  
13 gramme Trilafon that was in question in the Mental  
14 Health Association's brief, you will find that the  
15 8 milligramme tablets cost Schering from the parent  
16 company \$17.72 a 1,000 or \$1.72 each. Then you will  
17 find that the list of 50's is \$8.35, or 16¢ plus each.  
18 The retailer in 50's would pay \$5.01, or 10¢ each,  
19 and then in parentheses we might note that a hospital  
20 buying in 1,000's would pay \$70.22, or 7¢ each. I  
21 am taking the retailer's price at 10¢ buying in 50's,  
22 and that of course would be buying in rather small  
23 quantities, but let us keep it at 50's. The retailer  
24 would doubtless pay less in larger sums. Going the  
25 other side we find that this prescription was filled,  
26 and there, Mr. Chairman, I am going to ask to be  
27 permitted to put something on the record which is  
28 not in the brief, and I would be very glad to have  
29 it supplemented by a supplemental brief from the  
30



1 Canadian Mental Health Association, because they  
2 were good enough to give me details as to the prices  
3 paid when the Stelazine and Trilafon were obtained,  
4 and I would like to put to the witness, and I am  
5 sure that the people who I was in contact with at  
6 the Canadian Mental Health Association, actually the  
7 psychiatric nurse, Mrs. Oliver, who prepared this  
8 part of the brief, would be glad to supplement it  
9 with a supplementary brief. I am told that the  
10 prescription in this case called for 30 tablets, 8  
11 milligramme, one twice a day for 10 days, and one  
12 each morning, and at the Hudson's Bay store pharmacy  
13 they were obtained at \$5.94 for 30, approximately  
14 20¢ each. We find that on the Trilafon Schering  
15 pays \$1.07, the retailer 10¢, the prescription  
16 patient pays, if he is buying by the list, 15¢, but  
17 in this particular instance he paid a little more.  
18 We find factually in fact he paid 19¢ plus. Before  
19 I ask you any general question, I want to put Stela-  
20 zine on the record. Reading again from the Canadian  
21 Mental Health Association's brief: "Also through  
22 the White Cross Centre we have information on a  
23 middle aged woman who was discharged from a provin-  
24 cial mental hospital during the summer of 1960 on a  
25 maintenance dose of Stelazine. She has been employed  
26 as a housekeeper by a working mother with five chil-  
27 dren. Her total cash remuneration is \$40.00 a month,  
28 the cost of her medication is at least \$15.00 per  
29  
30



1 month. This proved to be an almost insurmountable  
2 problem for this woman and the probability is that  
3 the stress will ultimately send her back for further  
4 hospitalization".

5  
6 Now I will ask you to go to the Green  
7 Book, page 204, and you will find there the story of  
8 Stelazine, and I should put on the record, if I can  
9 pronounce it, the generic name which you will find at  
10 201, and it is triflupromazine dihydrochloride, and  
11 the Stelazine is Smith Kline & French brand name of  
12 that generic word which I have given you, and you  
13 find there if you follow the information and the arith-  
14 metic that I have made, and I should say at once that  
15 the tablet concerned that I want to ask you about is  
16 the 2-milligramme, you will find that Smith Kline &  
17 French buys the tablet for \$1.32 per 1,000 from its  
18 parent company in the United States, or S.K.F. pays  
19 one-third of a cent each for that tablet. You will  
20 also find that the list price in 50's is \$6.25, that  
21 the retailer's price in 500's is \$37.80, or 7½¢ each.

22  
23  
24  
25 -  
26  
27  
28 -  
29  
30



1 If you have trouble following that,  
2  
3 I have had to look at the brand, which is a Squibb  
4 equivalent, more or less. The retail price for 500  
5 is 7½¢ each. We may note the hospital would get it  
6 at 5½¢ when the hospital bought in lots of 500. Mr.  
7 Chairman, I would like to put into the record the  
8 information given me by Mrs. Oliver, the psychiatric  
9 nurse with the Canadian Mental Health Department,  
10 Alberta Branch. That is the prescription which is  
11 being referred to in the paragraph I read called  
12 for 2-milligramme tablets, 90-92 milligrammes to be  
13 taken three times a day. The patient would pay \$7.00  
14 for 50 or \$12.60 for 90 tablets, being one month's  
15 supply at approximately 14¢ per tablet. So summa-  
16 rizing with regard to Stelazine we find Smith Kline  
17 & French pay one-tenth of one cent, the retailer  
18 pays 7½¢ buying in 500's and the patient pays 14¢  
19 although the list price indicates the patient might  
20 pay in some places 12¢. Now, with these figures in  
21 front of you, Mr. Maday, I would like to ask you just  
22 a few questions. Does the retailer in Alberta buy  
23 direct from the drug manufacturer or always from the  
24 wholesaler?  
25

26 MR. MADAY: In bulk from the manufac-  
27 turer and perhaps - in bulk from the wholesaler -  
28 bulk buying, the majority of his buying is with the  
29 wholesaler and the other direct.

30 MR. FRAWLEY: Direct?



1 MR. MADAY: From the manufacturer.

2 MR. FRAWLEY: Most of the buying is  
3 done through the wholesaler?

4 MR. MADAY: That is right.

5 MR. FRAWLEY: He also buys some  
6 direct from the manufacturer?

7 MR. MADAY: That is right.

8 MR. FRAWLEY: That is at the option  
9 of the retailer?

10 MR. MADAY: That is right.

11 MR. FRAWLEY: If he wished he could  
12 buy everything direct from the drug manufacturer?

13 MR. MADAY: Not - he can't buy every-  
14 thing from the drug manufacturer. There are certain  
15 manufacturers will only distribute through whole-  
16 salers. If his volume is big enough he could no  
17 doubt order from the manufacturer and he will  
18 undoubtedly save and will be able to operate his  
19 pharmacy more efficiently.

20 MR. FRAWLEY: For instance he could  
21 buy in 500's and if he was only buying in 500's he  
22 would, of course, buy from the wholesaler?

23 MR. MADAY: Yes, but 500 is quite a  
24 large amount in a small store.

25 MR. FRAWLEY: Could he if he wished,  
26 subject to these few prohibitions, buy that also  
27 directly from the drug company?

28 MR. MADAY: Yes.





1 MR. FRAWLEY: You probably as you go  
2 along in purchasing your drugs and carrying on your  
3 business are not aware of the drug company's costs?

4 MR. MADAY: No sir, we are not.

5 MR. FRAWLEY: You weren't aware of  
6 them until you saw the Green Book?

7 MR. MADAY: That is right.

8 MR. FRAWLEY: You have had the Green  
9 Book for some time?

10 MR. MADAY: A short time.

11 MR. FRAWLEY: Until I directed your  
12 attention to these two psychiatric drugs this morning  
13 you probably hadn't pinpointed those particular  
14 costs?

15 MR. MADAY: I had pinpointed them.

16 MR. FRAWLEY: You had, you had already  
17 pinpointed them before?

18 MR. MADAY: Yes.

19 MR. FRAWLEY: You are just as curious  
20 as I was. I got this from the brief. You were  
21 prompted by other, and I am sure equally good motives.  
22 Have you ever protested to the drug manufacturer or  
23 to the drug wholesaler that have a tablet that costs  
24 Smith Kline & French one-tenth of one cent when they  
25 buy in the United States that to charge you 7½¢ when  
26 you have to resell it is indefensible? Have you ever  
27 taken that position with the drug manufacturer and if  
28 so what was the reaction?  
29  
30





1  
2 MR. MADAY: I can't take that attitude  
3 because I didn't know what the costs were.

4 MR. FRAWLEY: All right. Now that  
5 you know - I am not indicating or suggesting for a  
6 moment what you should do, but now that you know, let  
7 us assume you did protest to S.K.F. that was an  
8 outlandish price to be charging you. Let us call -  
9 I don't want to get into the use of big adjectives,  
10 let us say it is a very considerable mark-up, what  
11 would you expect to be the result? Do you think  
12 S.K.F. would immediately institute and establish a  
13 whole series of lower prices?

14 MR. MADAY: I don't think so, sir.  
15 I don't think they value my particular opinion. I  
16 know Smith Kline & French is very fair to the Govern-  
17 ment of Alberta in that they allow a grouping of  
18 bulk purchases of Stelazine and other drugs to the  
19 mental hospitals and the university hospitals. These  
20 are all grouped and when this group's combined  
21 purchases exceed a certain amount they give an  
22 extra discount, rebate to the Government.

23  
24 MR. FRAWLEY: In other words, what  
25 you are telling me, speaking of the Alberta Govern-  
26 ment, members of the Alberta mental hospitals and  
27 other hospitals can buy a good deal less than the  
28 hospital prices listed, namely six and two-fifths  
29 cents in 50's.

30 MR. MADAY: Yes.



1  
2 MR. FRAWLEY: How close could they  
3 get to S.K.F.'s one-tenth?

4 MR. MADAY: I don't know.

5 MR. FRAWLEY: In any event I don't  
6 want this for treatment in the hospital?

7 MR. MADAY: That is right.

8 MR. FRAWLEY: I am talking to you  
9 about what I am referring to is the pretty impor-  
10 tant situation namely the position of mental patients  
11 coming out and wanting to get through the period of  
12 latent emotionalism that still persists and needs  
13 drug therapy. We have been talking of two instances  
14 and what I suggest was rather a different situation.  
15 Without again making any allegations I ask you  
16 whether or not the price which the retailer pays  
17 was in any sense a hammered-out price, the result  
18 of bargaining between yourself as a buyer and S.K.F.  
19 as a seller.

20 MR. MADAY: No.

21 MR. FRAWLEY: I am not speaking of  
22 the Province of Alberta buying in large quantity  
23 for these hospital groups, I am talking about a  
24 person out on the street going to the retail drug-  
25 store. Would you say as far as you know that the  
26 price set by S.K.F. was not the result of any  
27 bargaining?  
28

29 MR. MADAY: No.

30 MR. FRAWLEY: Perhaps I might call



1 your attention - I don't want to put newspaper  
2 clippings in but the Edmonton Journal of 16th June  
3 of this year had an article which was headed Authori-  
4 tative Inquiry Imperative. I will only read one  
5 sentence. The object of this hearing, of course,  
6 must be to develop remedial measures which would  
7 return the drug industry to the normal discipline  
8 of a market place. That is an expression used many  
9 times. It struck me in this connection, do you  
10 think there is any normal discipline in the market  
11 place in the sale of Trilafon by S.K.F. to the  
12 retail drug trade?

13  
14 MR. MADAY: No, there isn't.

15 MR. FRAWLEY: Here is the price to  
16 the retailer on Trilafon - it is ten times the  
17 manufacturer's cost and on Stelazine - I am hesi-  
18 tant to do the arithmetic. It is one-tenth of one  
19 cent and  $7\frac{1}{2}\%$ , whatever percentage it turns out.  
20 You would agree it is the same thing with Trilafon,  
21 there doesn't seem to be much discipline in the  
22 market there?

23 THE CHAIRMAN: Mr. Frawley, to be  
24 quite clear - I may not have heard the right page.  
25 You referred to page 201?

26 MR. FRAWLEY: 201 for Stelazine.

27 THE CHAIRMAN: 2 milligrammes in 50's.  
28 You referred to page 204 and I thought that was also  
29 Stelazine.  
30



1 MR. FRAWLEY: No, I am sorry. I  
2 think I did say 204. I didn't mean it. I have no  
3 note for either Trilafon or Stelazine at page 204.  
4 That was an error. The pages concerned are 201 for  
5 Stelazine and 194 for Trilafon.  
6

7 MR. HOWARD: I wonder if the witness  
8 could be permitted to sit. He has been standing for  
9 an hour-and-half.

10 THE CHAIRMAN: Will you be long Mr.  
11 Frawley?

12 MR. FRAWLEY: Not too long.

13 THE CHAIRMAN: If you are going to be  
14 a few minutes we will continue.

15 MR. FRAWLEY: I don't think I will be  
16 longer than 15 minutes. I don't think so.

17 THE CHAIRMAN: Perhaps we had better  
18 adjourn.  
19

20 --- Short Recess  
21  
22  
23  
24  
25  
26  
27  
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1  
2 MR. FRAWLEY: Mr. Maday, just before  
3 I leave the discrepancy between the drug manufactu-  
4 rer's cost and the retail selling price, would you  
5 agree with me or what is your own view as to whether  
6 or not it appears that the retail over the counter  
7 price is - I mean for a prescription drug - the  
8 retail price is subsidizing the hospital price and  
9 those Government bid prices?

10 MR. MADAY: That might be correct,  
11 sir, I don't know.

12 MR. FRAWLEY: We do know that the  
13 Government buys in large, large quantities. For  
14 instance, the Alberta Government's programmes that  
15 were put in evidence, two of the programmes that were  
16 put in evidence at the Edmonton sittings, the Rheuma-  
17 tic Fever Prophylaxis Programme, Penicillin G and  
18 the Diabetic Tolbutamide Therapy Programme for Tolbu-  
19 tamides indicate that they in 1961 bought or are  
20 buying 156,000 of these Tolbutamide tablets and that  
21 in 1960-1961 they bought 192,500 of Penicillin G.  
22 For a small Province like Alberta those are a lot of  
23 tablets but nevertheless when you compare that to all  
24 of the prescriptions all over Canada that are being  
25 sold then, I take it, that the volume would be on the  
26 side of what is sold at the retail on prescription.

28 MR. MADAY: Possibly, sir.

29 THE CHAIRMAN: Mr. Frawley, I am  
30 wondering whether you have established that the witness



1 is in a position to say whether or not the manufacturers  
2 are paying a subsidy from the retail prices for perhaps  
3 losses on large - scale buying. I doubt if he is in a  
4 position to say that. He said "It might be but I don't  
5 know". I think that is as far as he can go.  
6

7 MR. FRAWLEY: We are only discussing it  
8 as to whether or not one branch of the market is subsi-  
9 dizing the other. That is all --

10 THE CHAIRMAN: He is not in a position  
11 to give any real evidence on it.

12 MR. FRAWLEY: No. I am just saying to  
13 him, Mr. Chairman, this is not the first time I have  
14 done it. I must not do it too much. We do know it  
15 is an accepted fact in the transportation economics  
16 that one class of traffic carries another. The old  
17 saying is "The boots and shoes must carry the sand  
18 and gravel".

19 THE CHAIRMAN: That has been proved  
20 with regard to that industry. This witness has said  
21 all he can say on that subject.  
22

23 MR. FRAWLEY: I want to get it on the  
24 record at least. I do want to get more than the  
25 question on the record, Mr. Chairman. I think that  
26 this man, holding the rather responsible position he  
27 does, he is President of this Association, in addition  
28 to being associated with the excellent University of  
29 Alberta, I thought while he was here I would ask him  
30 what he thought about the possibility that one branch





1 of the trade is perhaps subsidizing the other. I  
2 will pass from that.

3 Mr. Maday, now you have been made  
4 aware through this very thorough report made by the  
5 Directorats of the manufacturers' costs, do you  
6 think that we can look to any improvement in the  
7 price situation for the benefit of the sick people  
8 of this country who have to pay these expensive  
9 prices and indeed from the standpoint of the retailer,  
10 whose privilege it is to supply these consumers?

11 MR. MADAY: I couldn't say, sir. I  
12 don't know what the manufacturer requires to operate  
13 and whether he will have to fix his price to me.

14 MR. FRAWLEY: But you have told me that  
15 there has been no bargaining. I am wondering how  
16 strong the Alberta Pharmaceutical Association is to  
17 put this, to insist on putting them into a bargaining  
18 position with these drug manufacturers. Have you  
19 given any thought to that?

20 MR. MADAY: No sir.

21 MR. FRAWLEY: Well, in other words,  
22 you regard yourself as being an Association to look  
23 after the interests of the members and indeed of the  
24 public in general?

25 MR. MADAY: Yes sir.

26 MR. FRAWLEY: It is not worrying about  
27 whether or not the prices which the consumer has to  
28 pay are too high and whether anything can be done



1 about it, which is much more important.

2 MR. MADAY: The Association, that is  
3 the Alberta Pharmaceutical Association individually,  
4 has not done anything but I think that the records  
5 of the Canadian Pharmaceutical Association show  
6 there have been representations in the past; am I  
7 right? I think there has been various motions and  
8 various resolutions presented at the previous years,  
9 wherever possible, that proper prices should be  
10 available to the public. I believe that has been  
11 done.  
12

13 MR. FRAWLEY: Mr. Maday, again I don't  
14 want to be facetious. I have heard about motions  
15 and resolutions. I am just wondering if even at the  
16 national level there is any hope that the Canadian  
17 Pharmaceutical Association, representing all of the  
18 buyers, the retail buyers of this product, have got  
19 any bargaining strength to say to these drug companies,  
20 and I do not want to over-simplify it, to say to  
21 S.K.F. "7½¢ for a tablet that you bring over from  
22 the United States at one-tenth of a cent per tablet  
23 is just indefensible. We want a better price". I  
24 don't want to over-simplify this. What do you think?  
25 What are the possibilities along this line?  
26

27 MR. MADAY: I don't think that we  
28 have much of a chance, sir.

29 MR. FRAWLEY: You say you don't think -

30 MR. MADAY: We haven't much of a



1 chance.

2 MR. FRAWLEY: Do you think it is too  
3 much of a spread between one-tenth of a cent and  $7\frac{1}{2}\phi$   
4 to the retailer?

5 MR. MADAY: I don't know their opera-  
6 ting cost. I can't answer that.

7 MR. FRAWLEY: Do you think their  
8 operating costs would take up the difference between  
9 one-tenth of a cent and  $7\frac{1}{2}\phi$ ?  
10

11 MR. MACLEOD: He said he didn't know.

12 MR. HUME: He said he didn't know two  
13 or three times.

14 MR. FRAWLEY: You say you don't know.  
15 You just wish to leave it there?

16 MR. MADAY: I would like to leave it  
17 there.

18 MR. FRAWLEY: Mr. Maday, there are  
19 wholesalers in Alberta of drugs?

20 MR. MADAY: Yes sir.

21 MR. FRAWLEY: Are there very many?

22 MR. MADAY: Do you mean individual  
23 firms or are you referring to locations?

24 MR. FRAWLEY: Both. I was looking in  
25 the yellow pages of the Calgary telephone book. I  
26 found the Alberta National Drug Company are listed  
27 as wholesale druggists. Ayerst, McKenna and Harrison,  
28 they are manufacturers so they must just be the  
29 agents of the manufacturer.  
30



1 MR. MADAY: Yes, the depot.

2  
3 MR. FRAWLEY: Charles E. Frosst, that  
4 would be the same?

5 MR. MADAY: Yes.

6 MR. FRAWLEY: The next one is Gilbert  
7 and Company, Western Division. Do you know that  
8 company?

9 MR. MADAY: Yes sir.

10 MR. FRAWLEY: That is one of the  
11 people who specialize in drugs and sell them by the  
12 generic name?

13 MR. MADAY: Yes sir.

14 MR. FRAWLEY: Gilberts have a Western  
15 Division located in Calgary?

16 MR. MADAY: That is correct.

17 MR. FRAWLEY: Then there is one -  
18 Haver Lockhart Service. That is an ordinary whole-  
19 saler?

20 MR. MADAY: I believe he is a veteri-  
21 nary distributor.

22 MR. FRAWLEY: Yes. There is North-West  
23 Drug Company Limited, which is a wholesale drug?

24 MR. MADAY: A wholesale drug.

25 MR. FRAWLEY: So it seems we have in  
26 Alberta, the National Drug, North-West Drug, as being  
27 what you might call wholesalers of the ethical drugs  
28 and Gilbert and Company, Western Division, wholesalers  
29 of the generic drugs?  
30



1 MR. MADAY: Yes sir.

2  
3 MR. FRAWLEY: Now, is there a whole-  
4 salers' association in Alberta?

5 MR. MADAY: Not that I know of, sir.  
6 I can't answer the question.

7 MR. FRAWLEY: You don't know of any  
8 public representations which the wholesalers are  
9 going to make to this Commission?

10 MR. MADAY: I don't, sir.

11 THE CHAIRMAN: I think perhaps we  
12 might get clear on one point. You referred Mr. Maday  
13 to these two companies as being wholesalers of ethi-  
14 cal drugs. Do they not sell generic drugs too?

15 MR. MADAY: They would, sir, yes.

16 MR. FRAWLEY: National and North-West?

17 MR. MADAY: They may not handle every  
18 item. I haven't looked over their stock. I can't  
19 answer this fully but I would imagine they would  
20 supply a drug by a particular manufacturer other than  
21 Gilbert, if it was so called for.

22 MR. FRAWLEY: No, we are not concerned  
23 with Gilbert. The Chairman was referring to the two  
24 that I called mistakenly perhaps, Alberta National and  
25 North-West Drug and I referred to them as wholesalers  
26 of the ethical drugs. I am being corrected and I am  
27 glad, by the Chairman, that they also list generic  
28 drugs.  
29

30 MR. MADAY: They possibly do carry. I





1 don't know what their stocks are in there.

2 MR. HOWARD: Mr. Chairman, I don't  
3 know how this witness can give any evidence or opinion  
4 as to what a wholesaler has listed.

5 THE CHAIRMAN: Unless he buys from  
6 them.

7 MR. HOWARD: He doesn't know what  
8 they stock, Mr. Chairman.

9 THE CHAIRMAN: If he buys ethical drugs  
10 from these companies he knows they handle ethical  
11 drugs. If he buys generic drugs he knows they handle  
12 generic drugs.

13 MR. HOWARD: He knows them only for  
14 what he gets. He doesn't know what they stock.

15 MR. FRAWLEY: Do you know whether  
16 wholesalers apply sanctions to keep retailers in line  
17 in the matter of prices?

18 MR. MADAY: No sir.

19 THE CHAIRMAN: You don't know or they  
20 don't do it?

21 MR. MADAY: I don't know, sir.

22 MR. FRAWLEY: You don't know as a  
23 matter of fact. I will go a little further. Have  
24 you heard that wholesalers do impose sanctions to  
25 keep retailers in line in the matter of prices?

26 MR. MADAY: Would you repeat the ques-  
27 tion, please.

28 MR. FRAWLEY: Have you heard - you say  
29  
30





1 you don't know this as a fact, have you heard or has  
2 it come to your knowledge at all that wholesalers  
3 apply a sanction to retailers to keep them in line in  
4 the matter of prices? The expression "impose sanctions",  
5 does that trouble you?  
6

7 MR. MADAY: The question you are on --

8 MR. FRAWLEY: The question I am on is:  
9 do you know if the wholesalers of Alberta impose sanc-  
10 tions on retailers to keep them in line in the matter  
11 of prices?

12 MR. MADAY: Impose sanctions?

13 MR. FRAWLEY: They say "Your supply  
14 will be limited if you don't increase your prices"?

15 MR. MADAY: No.

16 MR. FRAWLEY: You know probably that a  
17 witness appeared before the Commission in Edmonton  
18 and said he had information, which he was not prepared  
19 to disclose, that there was a drug - I am not sure if  
20 it was a drugstore or some drugstores that were selling  
21 cheaper than the others and he was in danger of having  
22 his supplies reduced or cut off.

23 MR. MADAY: Yes.

24 MR. FRAWLEY: You are aware that that  
25 witness appeared before this Commission?  
26

27 MR. MADAY: Yes.

28 MR. FRAWLEY: Mr. Maday, is that the  
29 first time you ever heard of that sort of thing?

30 MR. MADAY: This is the first time, sir.



1 MR. FRAWLEY: You haven't heard of it  
2 at all before?

3 MR. MADAY: No. I haven't myself. I  
4 even - personally this struck me very funny in Edmon-  
5 ton. I wondered what could be the basis of it. It  
6 could possibly be he is unable to pay his bills so I  
7 contacted personally Alberta National Drug, contacted  
8 North-West Drug in Edmonton and contacted Parke-Davis  
9 Drug who are the only firms available in Edmonton who  
10 supply. They were all quite happy financially with  
11 him and no restrictions had been imposed, as far as I  
12 was told.  
13

14 MR. FRAWLEY: Mr. Maday, I ran across  
15 an advertisement in the Edmonton Journal of the 25th  
16 July which I would like to show you. You can judge  
17 the importance of it more than I. This is an adver-  
18 tisement of Mid-Town Drugs. They operate in the  
19 Union Bus Depot at 102nd Street in Edmonton and I will  
20 just put the advertisement into the record. It reads:  
21 "Six Good Reasons to take your prescriptions to Mid-  
22 Town Drugs.  
23

- 24 1. Lowest prices in Edmonton.
- 25 2. Average savings up to 30%-40%.
- 26 3. We charge ONLY our cost plus one  
27 dollar professional fee.
- 28 4. Prescriptions filled EXACTLY as  
29 your doctor orders.
- 30 5. Absolutely quality drugs.



1 6. Two experienced pharmacists to  
2 serve you".

3 Is there anything at all out of line  
4 with this advertisement?

5 MR. MADAY: Yes, there is.

6 MR. FRAWLEY: What is it that is out  
7 of line or exceptional or objectionable?

8 MR. MADAY: We object - I would object,  
9 sir, to the fact that he implies that other stores  
10 do not - this is on the basis of professional - he  
11 implies that prescriptions are not filled exactly as  
12 the doctor orders by other pharmacists. He implies  
13 that other stores do not have pharmacists, do not  
14 use quality drugs.

15 He implies that his pharmacists are  
16 experienced and other pharmacists are not experienced.

17 I would say I am experienced and I  
18 maybe do not advertise it.

19 MR. FRAWLEY: Are those the only infe-  
20 rences you draw from this?

21 MR. MADAY: Yes.

22 MR. FRAWLEY: Mr. Maday, I certainly  
23 don't want my examination to become controversial at  
24 all but when you say that a person advertises that he  
25 has two experienced pharmacists to serve you, I put  
26 it very politely and suggest to you that contains no  
27 inference whatever that any other drugstore in Edmon-  
28 ton has not experienced pharmacists.



1 THE CHAIRMAN: I think that is a matter  
2 of opinion. He has given his opinion, Mr. Frawley.

3 MR. MADAY: The advertisement, "he  
4 has two pharmacists" is all he needs to say. He  
5 doesn't need to say they are experienced.

6 THE CHAIRMAN: The witness' interpre-  
7 tation does not accord with yours, that is all, Mr.  
8 Frawley.

9 MR. FRAWLEY: How about No. 2: "Average  
10 savings up to 30%-40%"?

11 MR. MADAY: I don't think No. 2 should  
12 be there. No. 2 is an offshoot of No. 1. He has  
13 other prices which are lower. He says his savings  
14 are 30%-40%. He has no six reasons there.

15 MR. FRAWLEY: You say he has only five  
16 reasons instead of six. I would have thought the  
17 very first one you would have objected to was No. 1  
18 and No. 2: "Lowest prices in Edmonton" - "Average  
19 savings up to 30%-40%".

20 MR. MADAY: No sir.

21 MR. FRAWLEY: Suppose he was charging  
22 less than the average run of prices in Edmonton drug-  
23 stores. Just suppose he was because he was selling  
24 at 30% or 40%. I suggest to you that means to me  
25 he is selling at list less 40% or at any rate his net.  
26 I suggest that is what he really meant, when you look  
27 at it at first, simply regarding his cost at list  
28 less 40%, which is a perfectly good starting place to  
29  
30



1 fix his own retail prices.

2 MR. MADAY: If he feels so, yes.

3 MR. FRAWLEY: And then he can make  
4 his profit by his professional fee, which he says  
5 is a dollar, so I wouldn't think there was anything  
6 wrong with him saying: "I will sell to you at my  
7 cost, which is list less 40%, and charge a dollar  
8 for the things I have to do in filling the prescrip-  
9 tion". There is nothing objectionable about that?

10 MR. MADAY: No, except I would say it  
11 is not two statements, it is one. I think his adver-  
12 tising is misleading.

13 MR. FRAWLEY: You did tell the Chairman  
14 that the great majority of pharmacists do adhere  
15 pretty rigidly to the list price, and I would like  
16 in that regard to call your attention to the Green  
17 Book at page 89, and I would like to invite your  
18 comments. Page 89, the paragraphs 151 and 152: "Despite  
19 the fact there is no legal compulsion to do so, in  
20 Canada manufacturers' list or suggested resale prices  
21 seem to be adhered to almost without exception by  
22 retail druggists. There appear to be several  
23 reasons.

24 First, most manufacturers' and distri-  
25 butors' price lists (except those setting out net  
26 prices to hospitals) usually show list or suggested  
27 resale prices. The actual prices to the wholesaler,  
28 the retailer, the dispensing physician and other  
29  
30



1 trade buyers are determined by applying the appli-  
2 cable discounts. Thus, all down the line from the  
3 manufacturer, the list price is used and comes to be  
4 regarded as "the price". To put it another way, sup-  
5 pose a certain sized package of a drug carries a list  
6 or suggested resale price of \$1.00. A retailer would  
7 normally buy at a discount of 40 per cent or at a  
8 cost of 60 cents. However, he does not look on the  
9 article as one which he purchased for 60 cents and  
10 proceed to mark it up on that basis. Rather, the  
11 article is looked upon as the \$1.00 size of the parti-  
12 cular product, to be sold at \$1.00, regardless of  
13 whether it was purchased under a special deal or on  
14 other more favourable than usual terms or whether it  
15 was purchased on less favourable than usual terms".  
16

17 Do you agree that the Director has  
18 pretty well recorded the situation in Canada in  
19 those paragraphs?

20 MR. MADAY: Yes, he has. If I may  
21 clarify something for the Commission, it is that  
22 when the cost is 60 cents, which means that that is  
23 the cost from the wholesaler when it comes in the  
24 back door of the pharmacy. Immediately the pharma-  
25 cist regards this as a starting point. He cannot  
26 say this is the cost, because the very fact that one  
27 of his personnel takes the box and puts it on the  
28 shelf and marks off the invoice, and delivers it to  
29 the dispensary for putting up into the dispensary  
30





1 shelf, has already cost money, plus the rent, light,  
2 heat and so on, so he cannot base on each individual  
3 item that it would carry an extra 12, 13 or 20 cents,  
4 so that product no longer costs him 60 cents, but 80  
5 cents or thereabouts, and therefore we in pharmacy  
6 have taken the other approach, and say if we take  
7 the suggested list price on which we presume we make 40%,  
8 then the overall picture will end up with a certain  
9 net result.  
10

11 THE CHAIRMAN: As far as that goes,  
12 it is the basis in all other retail businesses, they  
13 all have overhead expense.

14 MR. FRAWLEY: When the bottle of tablets  
15 arrives in your pharmacy it costs 60 cents?

16 MR. MADAY: That is right.

17 MR. FRAWLEY: That is your starting  
18 point. The problem is that the Director suggests  
19 that the average pharmacist in Canada does not seem  
20 to regard that as his cost and build it up. He  
21 simply says this is a dollar item, I will have 40 cents  
22 to take care of my costs, and I will add a prescrip-  
23 tion fee. The Mid-Town Drugs simply says we will  
24 sell it to you at 60 cents and charge a professional  
25 fee, but the other druggist says we will charge a  
26 dollar, and add a professional fee. There is quite  
27 a large margin there and I think we should explore it.  
28

29 If Mid-Town Drugs, just one man in  
30 one city, is pointing the way, perhaps it is worth



1 giving second thought to it. What do you think about  
2 the druggist simply taking his list less 40% and  
3 adding what he thinks is a fair profit, and fixing a  
4 price on that, and never mind the list price?

5 MR. MADAY: That of course is possible,  
6 but I would like to clarify that our understanding of  
7 Mid-Town's operations is that this man pays an 8%  
8 rental on the selling price, on his gross take, where  
9 normal pharmacies it works out to between 2.5 or 3  
10 or 3.5% of the sale. We think that is a little higher.  
11 We don't know for a fact, but we believe that state-  
12 ment is a little ambiguous. He says our cost. What  
13 does he mean by our cost? Does he mean that the fact  
14 that the prescription costs 60¢, does he say the cost  
15 of my operation, I have done 16 prescriptions, and  
16 light and other overhead costs, so-and-so, does he  
17 make it 90¢ plus a dollar? We don't know.

18 THE CHAIRMAN: I don't think we are  
19 concerned with his detailed way of operating.

20 MR. FRAWLEY: Do you mean he pays 8%  
21 of his take for rent?

22 MR. MADAY: That is right.

23 MR. FRAWLEY: Well, everybody has to  
24 pay rent. I saw no special brief. I just saw that  
25 reading the newspaper and clipped it out. Do you  
26 think it is worthwhile to go and talk to that man,  
27 not in a belligerent way, but in a friendly construc-  
28 tive way, to see whether or not he has found a way  
29  
30



1 to bring down the price of drugs?

2 MR. MADAY: Yes, we will be talking to  
3 him.

4 MR. FRAWLEY: You wouldn't brush that  
5 fellow aside and say he is just an outlaw and we  
6 won't pay any attention to him?

7 MR. MADAY: No.

8 MR. FRAWLEY: That is very good. I  
9 am glad to know that. Page 90 of the Green Book  
10 refers to at the top of the page, a heading: "Wide  
11 use is made throughout the trade of a composite  
12 price book". Who publishes that?

13 MR. MADAY: Unless the Commission  
14 knows. Perhaps -- is this the book that is published  
15 as a guide for retail prices on front store merchan-  
16 dise, as compiled possibly by the Canadian Pharmaceu-  
17 tical Association?

18 MR. FRAWLEY: I don't know. It says:  
19 "Not only do manufacturers' price lists show sugges-  
20 ted resale prices, but wide use is made throughout  
21 the trade of a composite price book which shows the  
22 suggested resale price for virtually every product  
23 sold in a drug store, from the most complicated drug  
24 to items such as pocket combs. Use of this book  
25 tends to reinforce the concept of a suggested resale  
26 price being 'the price' for any particular item". I  
27 just want to know whose price list this was. Is it  
28 prepared by the national edition of your Association,  
29  
30



1 the Canadian Pharmaceutical Association?

2 MR. MACLEOD: Perhaps I can interject  
3 here. It is explained elsewhere in the statement  
4 that the pricing material used in British Columbia,  
5 and to some extent in the Province of Alberta,  
6 differed from that used in other parts of Canada.  
7 There is a service published in Vancouver, the  
8 Druggists' Bulletin Service, D.B.S., which found  
9 wide acceptance in British Columbia. The exact  
10 extent we couldn't establish, but it is used to a  
11 large extent in Alberta, so the use of this book,  
12 the price book published by the Canadian Pharmaceu-  
13 tical Journal, the use was much less common in  
14 Alberta, because they had the substitute system, and  
15 it is made clear in other parts of the statement.

16 MR. MADAY: This book does cover the  
17 front store mostly though.

18 MR. MACLEOD: And prescription items  
19 as well.

20 THE CHAIRMAN: Are you familiar with  
21 that book at all?

22 MR. MADAY: I have seen it in the past,  
23 yes.

24 MR. FRAWLEY: But Mr. MacLeod is right  
25 when he says it is not in widespread use in Alberta?

26 MR. MADAY: I don't know.

27 MR. FRAWLEY: Have you seen it in many  
28 drugstores?  
29  
30



1 MR. MADAY: I have old editions in my  
2 store.

3 MR. FRAWLEY: As a druggist, you have  
4 access to all manufacturers of drugs?

5 MR. MADAY: Yes.

6 MR. FRAWLEY: And there is no doubt  
7 about it, you could have access to Gilbert and  
8 Company, which I know little about except it seems to  
9 be a company which specializes in the distribution of  
10 drugs by generic name, and druggists in Alberta have  
11 perfectly free access to purchase from that company?

12 MR. MADAY: That is right.

13 MR. FRAWLEY: And I take it the same  
14 probably with regard to Empire, which I found referred  
15 to on page 284 as Winter Laboratories Limited, (Empire  
16 Laboratories Ltd. Dominion Pharmacal).

17 MR. MACLEOD: There are a series of  
18 associated companies, the same man or the same company  
19 operates them. One portion is Empire, another is  
20 Winter, and one is Dominion, and they are inter-con-  
21 nected and the same group.

22 MR. FRAWLEY: And they are the group  
23 who are best known for the fact that they do deal in  
24 drugs by their generic name?

25 MR. MACLEOD: That is correct.

26 MR. FRAWLEY: So there would be no  
27 problem in obtaining the drugs by their generic name,  
28 there being quite ample wholesale outlets for these  
29  
30



1 drugs. You have perhaps seen the Province of Alberta's  
2 brief, and are aware of the programmes which Dr. Ross  
3 indicated in Edmonton. I can assume that there is no  
4 objection whatever from the retail pharmacists of  
5 Alberta to these programmes of the Provincial Govern-  
6 ment?

7  
8 MR. MADAY: The Programme was not in full  
9 detail. I don't know exactly whether it is fully,  
10 I am aware of the Rheumatic Fever, the Diabetic, but  
11 of the Steroid I am not aware. The only thing I  
12 could say is that referring in our brief on page 3  
13 what the Alberta Pharmaceutical Act states, and it  
14 makes it illegal for anyone to dispense, and only a  
15 pharmacist or a registered pharmaceutical student  
16 interne can dispense under the supervision of a phar-  
17 macist. If there is nothing contrary to the Act, we  
18 certainly have no objection to it.

19  
20 MR. FRAWLEY: Thank you for pointing  
21 out the legal matters. Assuming that no statute is  
22 being breached by these provincial programmes, I  
23 suppose they could all be validated by statute if  
24 necessary, but what you might call the moral aspects  
25 of the programme are perfectly acceptable to the  
26 retailers as retailers as well as they are perhaps  
27 to the retailers as ordinary citizens?

28 MR. MADAY: That is right.

29 MR. FRAWLEY: And any enlargement of  
30 that programme along the same lines would be equally





1 acceptable?

2 MR. MADAY: That is right.

3 MR. HUME: Mr. Maday, I think I could  
4 get at this through cross-examination with a bit of  
5 time, but perhaps my friend Mr. Frawley will make  
6 this unnecessary by agreeing with me that in the  
7 questions that were asked of Mr. Maday, Mr. Frawley  
8 took what he called the manufacturer's cost in the  
9 Green Book, and then the word I think was his, the  
10 indefensible difference between that cost --

11 MR. FRAWLEY: I don't want my friend  
12 to say I called them indefensible.

13 MR. HUME: The word was used, and the  
14 transcript will show who used it. The Green Book  
15 very carefully indicates that it is not the manufac-  
16 turer's cost, but the cost of the products, the actual  
17 powder laid down with transportation and tariff, and  
18 does not include the costs incurred in Canada, such  
19 as income tax and sales tax, packaging and so on, so  
20 I think Mr. Frawley, you will agree that your reference  
21 there to cost is not the manufacturer's cost, but  
22 merely the laid down cost of the product itself. And  
23 you indicated that you didn't have any knowledge what  
24 the manufacturer's costs were once he got the powder  
25 in your back door. You know what the cost to the  
26 pharmacists in Alberta is, but not what the cost to  
27 the manufacturer is?

28 MR. MADAY: That is right.  
29  
30



B/dpw

1 MR. HUME: You indicated you didn't  
2 have any knowledge what the manufacturer's costs were  
3 once he got the powder in his back door. You could  
4 tell us what your costs are as a pharmacist in Alberta  
5 but you don't know what his costs are. I have two  
6 points I want to cover with you. The first, Mr. Maday,  
7 I wonder if you would be good enough to turn to page 4  
8 mentioning the statistics based upon the survey you  
9 made. I think I am clear on it but in case there is  
10 any doubt in my mind or anybody else's, am I correct  
11 in the survey you made in round figures 90% of the  
12 prescriptions that were filled in the survey in using  
13 brand names were filled because the doctor in writing  
14 prescribed or required you to do so?  
15

16 MR. MADAY: Oh, yes.

17 MR. HUME: Would that figure include  
18 any prescriptions that would be written by the doctor  
19 without such a requirement and which the druggist  
20 must decide what he would use, a generic name to  
21 which has been attached a manufacturer's label, a  
22 brand name, or replace that where the doctor has  
23 used a brand name in writing the scroll?  
24

25 MR. MADAY: I am sure it is where the  
26 doctor had stated the brand name.

27 MR. HUME: In the 6.69% these would  
28 be, am I clear these would be written by a doctor in  
29 which he used the generic name of the drug without  
30 indicating a label? In other words, the doctor was



1 indifferent where the product was manufactured? I  
2 don't mean indifferent in any obnoxious sense, the  
3 doctor merely used the generic name without indica-  
4 ting whose generic drug he wanted to use.

5 MR. MADAY: I think that would be  
6 right.  
7

8 MR. HUME: In the remaining ones,  
9 would some of this 3.9% - would some of those be  
10 written by the doctor where he would use a brand  
11 name and some use a generic name or would there be  
12 no reference in the prescription to either one?

13 MR. MADAY: I can't recall, Mr. Hume,  
14 sufficiently well on these 3,000 prescriptions. I  
15 would think it would be quite feasible it could be  
16 brand name. I want to give you an example. The  
17 doctor might say give B-Plex, and Phenobarbital.  
18 B-Plex is the brand name.

19 MR. HUME: In the 3.9 there may be  
20 some brand name reference by the doctor?

21 MR. MADAY: Yes.

22 MR. HUME: This may not be too signi-  
23 ficant but for my own clarification, these figures  
24 I realise are a cross-section and there is a possible  
25 overlap. As a pharmacist may I ask you this question?  
26 Where the doctor in the 6.69% wrote a prescription  
27 using generic terminology does the doctor ever indi-  
28 cate whose generic drug he wants you to use? Empire  
29 or Gilbert?  
30



1 MR. MADAY: You mean personally? In  
2 generic terminology he often uses the company.

3 MR. HUME: So when the doctor writes  
4 a prescription using generic terminology and indicates  
5 the source of the terminology he is doing the same  
6 as writing a brand name prescription?

7 MR. MADAY: Yes.

8 MR. HUME: Yes, thank you. In other  
9 words, in your profession a brand name is a generic  
10 name with a specific identifying label on it?

11 MR. MADAY: That is right. It is  
12 quite thoroughly set forth in our University formulary.  
13 I don't know if I should interject those remarks.

14 MR. HUME: I think, Mr. Maday, reading  
15 the transcripts and what I have heard to date there  
16 is a fair amount of confusion. There seems to be  
17 some misunderstanding. The magic name generic  
18 doesn't necessarily wipe out the connotation these  
19 products are identified. There are some very promi-  
20 nent and well-known generic manufacturers.

21 MR. MADAY: Yes sir.

22 MR. HUME: These manufacturers are  
23 trying to get you to buy their drugs?

24 MR. MADAY: That is right.

25 MR. HUME: They are doing just the  
26 same as any other manufacturer. May I ask you to  
27 turn to page 5 of your submission. In the first  
28 paragraph you say "It would follow therefore that  
29  
30



1 the inference that the pharmacists could immediately  
2 effect an appreciable saving by adding to their  
3 inventory a line of generic drugs is not accurate.  
4 Such a step would serve only to add greatly to the  
5 inventory" and so on. If the law were changed the  
6 way it was suggested in the press so that if a pro-  
7 duct, a generic - a brand name is used which is a  
8 generic name and you were free as a pharmacist to  
9 fill that with any generic name drug you wanted,  
10 would you, as an experienced pharmacist, believe  
11 that would make very much difference to the way you  
12 fill prescriptions?  
13

14 MR. MADAY: No sir.

15 MR. HUME: I am getting into an area  
16 where I can't pronounce most of the generic names.  
17 They are much larger than the brand names.

18 MR. MADAY: Yes sir.

19 MR. HUME: May I interject to say that  
20 is why doctors prefer brand names because they don't  
21 have to write 32 letters instead of 9; is that  
22 possible?  
23

24 MR. MADAY: It could be possible.

25 MR. FRAWLEY: At our expense.

26 MR. HUME: It may be. If the law  
27 were changed from your experience as a pharmacist  
28 filling prescriptions, would you think the percentage  
29 indicated by the survey would be much altered, from  
30 your own experience?



1 MR. MADAY: No.

2 MR. HUME: You wouldn't think so,  
3 thank you. I think probably you have summed it up  
4 on page 6 "It follows that the pharmacist must of  
5 necessity be forced to rely on those drugs which  
6 through experience he knows can be relied on to  
7 satisfy the requirements of safety and efficacy".  
8 That sums it up?

9 MR. MADAY: Yes.

10 MR. HUME: It is true whether it is  
11 manufactured and distributed by one of the companies  
12 that specializes in generic drugs or a brand name  
13 manufacturer?

14 MR. MADAY: Yes.

15 MR. HUME: Yes, thank you and thank  
16 you Mr. Chairman.

17 THE CHAIRMAN: Mr. MacLeod?

18 MR. MACLEOD: Do you have a Code of  
19 Ethics in your Association?

20 MR. MADAY: Yes sir.

21 MR. MACLEOD: Do you have a copy here  
22 you can produce?

23 MR. MADAY: I haven't. I could make  
24 it available.

25 MR. MACLEOD: Can you make a copy  
26 available to the Commission at a later date, send  
27 it in?

28 MR. MADAY: Yes.

29  
30





1 MR. CAMERON: May I speak? There  
2 isn't a separate code for Alberta. We adopt the  
3 Canadian Pharmaceutical Code of Ethics.

4 MR. MACLEOD: You adopt the Code for  
5 the Canadian Pharmaceutical Association. Do you  
6 know if that has been given statutory authority in  
7 this Province? Is that under virtue of the Act you  
8 refer to in your brief?

9  
10 MR. MADAY: It doesn't say.

11 MR. MACLEOD: You don't know?

12 MR. MADAY: I am sure it doesn't say.

13 MR. MACLEOD: Have you got a copy of  
14 the prescription guide recommended by the Association  
15 that you can produce? Is this the guide which is  
16 referred to on page 174 - page 100, paragraph 174 of  
17 the material, the Green Book?

18 MR. MADAY: Yes, that would be, sir.

19 MR. MACLEOD: Headed Professional Fee,  
20 Schedule for Prescriptions Compounded in the Pharmacy  
21 on one side and Calculator for all Prefabricated  
22 Preparations or Specialties on the other. Does this  
23 guide prescribe a minimum fee?

24 MR. MADAY: Calculated minimum price  
25 can't be less than \$1.05.

26 MR. MACLEOD: Minimum fee of \$1.05.  
27 Does the guide provide any additional...

28 MR. FORSYTH: The word I think was not  
29 fee of less than \$1.05. I think it is price.  
30



1 MR. MACLEOD: That is quite right,  
2 minimum price \$1.05. Does the guide suggest the use  
3 of the fee, an additional fee where a narcotic is  
4 dispensed?

5 MR. MADAY: Yes.

6 MR. MACLEOD: Does it also suggest  
7 the use of an additional fee where there is a poiso-  
8 nous entry?

9 MR. MADAY: No.

10 MR. MACLEOD: Are there any cases  
11 besides the case of dispensing a narcotic where  
12 there is an additional fee over and above the regu-  
13 lar fee added, that you know of?

14 MR. MADAY: No.

15 MR. MACLEOD: Why is the additional  
16 fee added in the case of a prescription involving a  
17 narcotic?

18 MR. MADAY: The basis of this whole  
19 fee schedule is cost and time involved. It takes  
20 longer to make all the necessary reportings for the  
21 narcotic registration and therefore an additional  
22 15¢ is charged. It is not only at the time of the  
23 prescription being in there. It has to be filed  
24 separately and quarterly or monthly for audit pur-  
25 poses an inspector comes and this takes up time.

26 MR. MACLEOD: So there is an addi-  
27 tional fee to cover that additional time involved?

28 MR. MADAY: That is right.  
29  
30



1 THE CHAIRMAN: Mr. MacLeod, I think  
2 we had better file this as an exhibit.

3 MR. MACLEOD: Yes. It may be diffi-  
4 cult to mark.

5 THE CHAIRMAN: You have no objection  
6 to this being filed?

7 MR. FORSYTH: No sir, not at all.

8 THE CHAIRMAN: This will be C.1.

9  
10  
11 --- EXHIBIT NO. C.1: Calculator.

12  
13 MR. MACLEOD: Does the guide contain  
14 any suggestion that the price for the prescription  
15 be marked on the prescription in code?

16 MR. MADAY: It doesn't suggest. It  
17 says all copies of prescriptions and new prescrip-  
18 tions on which prices have been quoted must be coded.

19 MR. MACLEOD: Which means what?

20 MR. MADAY: It means coded for pharma-  
21 cists that would be filling the prescription.

22 MR. MACLEOD: Do you understand that  
23 suggestion to refer to prescriptions that are merely  
24 handed to you for pricing, you don't actually fill?

25 MR. MADAY: That is correct.

26 MR. MACLEOD: Do you personally in  
27 your own practice follow that?

28 MR. MADAY: Not at all times, sir.

29 MR. MACLEOD: When are the exceptions  
30



1 made?

2 MR. MADAY: When the patient has  
3 brought in a prescription and asked for a price and  
4 retained the prescription in his possession which  
5 doesn't allow me time to mark costs or where the  
6 patient is just asking verbally.

7 MR. FRAWLEY: Would you mind raising  
8 your voice.

9 MR. MADAY: When they are just asking  
10 for the price without giving me the prescription.

11 MR. MACLEOD: You do when you get an  
12 opportunity to code the prescription?

13 MR. MADAY: Yes.

14 MR. MACLEOD: Can you express any opinion  
15 as to the extent to which that practice is followed  
16 by other pharmacists in this area?

17 MR. MADAY: I would imagine it is in  
18 the majority of cases, unless there are circumstances  
19 where they can't.

20 MR. MACLEOD: If you will just look at  
21 page 100, paragraph 174 again. You have read this  
22 document, have you?

23 MR. MADAY: Yes.

24 MR. MACLEOD: Does the paragraph  
25 correctly set out the factual situation as regards  
26 Alberta?

27 MR. MADAY: Page 100?

28 MR. MACLEOD: Page 100, paragraph 174.

29

30



1 MR. MADAY: You refer to the standar-  
2 dized pricing programme?

3 MR. MACLEOD: The paragraph was inten-  
4 ded to give a summary of the situation in Alberta,  
5 the fact the D.B.S. or Druggists' Bulletin Service  
6 had previously been used and it has been largely  
7 replaced as of 1960 by the Schedule we have been  
8 looking at. Is that factually correct?

9 MR. MADAY: Yes.

10 THE CHAIRMAN: The answer was what?

11 MR. MADAY: Yes.

12 MR. MACLEOD: There was some discus-  
13 sion with members of the Commission and, I think,  
14 with other counsel as to the prices you pay when you  
15 buy from wholesalers. Is it generally true when you  
16 buy direct from the manufacturer you get a better  
17 price than when you have to buy from the wholesaler?

18 MR. MADAY: Generally.

19 MR. MACLEOD: Generally true. To what  
20 extent do you rely on wholesalers to back you up in  
21 the matter of stock?

22 MR. MADAY: Extensively.

23 MR. MACLEOD: Can you call on the  
24 wholesaler if you receive a prescription for an item  
25 which you don't have in stock at the moment, can you  
26 get it from the wholesaler quite quickly?

27 MR. MADAY: Yes. Then, of course, you  
28 have to take into account the suburbs which require  
29  
30



1 a length of time to travel. It is general to try and  
2 obtain it from a neighbouring pharmacy, the prescrip-  
3 tion of the product required and to replace it.

4 MR. MACLEOD: The wholesaler does give  
5 you certain protection and you don't have to carry the  
6 same amount of stock you would have to carry if the  
7 wholesaler was not in town?

8 MR. MADAY: That is correct, yes sir.

9 THE CHAIRMAN: That raises the question  
10 about outlying pharmacists in small towns. Do they  
11 have to carry larger stock?

12 MR. MADAY: Larger stock. Quite fre-  
13 quently when the doctor knows he is prescribing - out  
14 of the hospital he knows he is prescribing a new drug  
15 and it is limited, there is a possibility it is not  
16 in the outlying areas as yet and the hospital pharmacy  
17 has it and will issue the patient with enough to  
18 carry him until that pharmacist can obtain a stock.  
19 It also follows if there are any experimental drugs  
20 used in the hospital and the patient is being dis-  
21 charged the hospital very happily relabels the drug  
22 so the patient would know what the dosage schedule is  
23 and give him enough to carry on with.

24 MR. MACLEOD: I want to ask you a ques-  
25 tion or two about the breakdown of prescriptions on  
26 page 4 with particular reference to the 243 prescrip-  
27 tions which were written using generic terminology.  
28 Wouldn't some of those be for products of what we  
29  
30





1 might call the ethical companies?

2 MR. MADAY: Oh, yes.

3 MR. MACLEOD: Have you ever dispensed  
4 streptomycin or dihydrostreptomycin?

5 MR. MADAY: Yes.

6 MR. MACLEOD: Is that sold by any  
7 company, even the most ethical company, under a trade  
8 name?  
9

10 MR. MADAY: Yes, Glaxo-Allenburys  
11 Canada Limited have one known as Strepaline 33. It  
12 is a solution of streptomycin. It has 1 gramme of  
13 streptomycin and 3 cc's in one vial. It is known  
14 commercially as Strepaline. It is a sulphate.

15 MR. MACLEOD: Subject to that excep-  
16 tion don't most large companies market streptomycin  
17 or dihydrostreptomycin simply under those names?

18 MR. MADAY: That is correct.

19 MR. MACLEOD: Unless the doctor  
20 wanted that particular product that you referred to  
21 a moment ago he would simply write the generic name?  
22

23 MR. MADAY: Yes.

24 MR. MACLEOD: Does that mean you only  
25 have to stock one brand of streptomycin or dihydro-  
26 streptomycin?

27 MR. MADAY: That is correct.

28 MR. MACLEOD: Of a multiplicity of  
29 brands?

30 MR. MADAY: That is correct.



1 MR. MACLEOD: How many brands of  
2 penicillin do you stock?

3 MR. MADAY: At my private establish-  
4 ment, store?

5 MR. MACLEOD: Yes.

6 MR. MADAY: As a guess, eight.

7 MR. MACLEOD: Would these be essen-  
8 tially duplicates of each other?

9 MR. MADAY: Some and various dosage  
10 forms.

11 MR. MACLEOD: Can you name the brand  
12 names of the eight?

13 MR. MADAY: P.G.A., Hylenta, Forpen -  
14 do you mean straight penicillin or in salt?

15 MR. MACLEOD: You said you had eight  
16 brands.

17 MR. MADAY: V-cillin, P.G.A., Hylenta,  
18 Forpen, Syn-cillen, Pen-Vee - I won't mention the  
19 combinations.  
20  
21  
22  
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1 MR. MACLEOD: Perhaps that is enough.  
2 Is V-cillin penicillin B or penicillin D potassium?

3 MR. MADAY: V-cillin is penicillin B.  
4 V-cillin K is penicillin B potassium.

5 MR. MACLEOD: I am just wondering if  
6 in fact it is not a little more difficult to remember  
7 the particular names in these cases than simply the  
8 name "penicillin".

9 MR. MADAY: Yes sir.

10 MR. MACLEOD: Would that not apply to  
11 an awful lot of drugs?

12 MR. MADAY: No sir.

13 MR. MACLEOD: It would not?

14 MR. MADAY: No sir.

15 MR. MACLEOD: Would it not apply to  
16 the tetracyclines?

17 MR. MADAY: Yes.

18 MR. MACLEOD: To what antibiotics  
19 would it not apply among the very well known ones;  
20 I suppose aureomycin and terramycin, which are  
21 products of one company?

22 MR. MADAY: Yes, two companies. I  
23 would have to look -- it is pretty hard from memory,  
24 sir.

25 MR. MACLEOD: I suggest to you that  
26 it would be much easier for a doctor to prescribe  
27 tetracycline than to try to look up one of the six  
28 or eight brands that are on the market and get the  
29  
30



1 trade name for it.

2 MR. MADAY: Yes, it is perhaps diffi-  
3 cult for a doctor to try to remember everything, to  
4 classify everything.

5 MR. MACLEOD: So I suggest the argu-  
6 ment that is being advanced that the use of trade  
7 names has simplified things for the doctors has to  
8 be examined with great care. Is that not true?

9 MR. MADAY: The use of simplified  
10 names can, in most instances, be helpful in very  
11 many preparations of which there is no generic name  
12 so there is two sides to it.

13 MR. MACLEOD: There are two sides to  
14 it. But it is not the open and shut argument that  
15 has been presented to us sometimes that the trade  
16 name is easier.

17 MR. MADAY: No.

18 MR. MACLEOD: You spoke in answer to  
19 a question by Commissioner Whiteley, I think, about  
20 the sources of knowledge of the druggist. You  
21 mentioned some of the text books.

22 MR. MADAY: Yes.

23 MR. MACLEOD: Now, these are rather  
24 slow in coming out in relation to the newest drugs,  
25 are they not?

26 MR. MADAY: That is correct.

27 MR. MACLEOD: For a considerable  
28 period of time wouldn't the pharmacist have to rely  
29  
30



1 on information supplied by the manufacturer?

2 MR. MADAY: Yes sir, he would.

3 MR. MACLEOD: Would you expect in the  
4 ordinary pharmacy to find an any more complete des-  
5 cription and information about the new drugs than  
6 shown in the Compendium of Pharmacy Specialties by  
7 Dean Hughes of Toronto?

8 MR. MADAY: I would.

9 MR. MACLEOD: What would you expect  
10 to find?

11 MR. MADAY: I would possibly expect  
12 to find "new and information official drugs compen-  
13 dium". I would expect to find an index put out by  
14 a compilation, in much the form you have it there,  
15 sir, in the journals, on the top of your desk - the  
16 Drug Merchandising one. I would also expect possibly  
17 they should have --

18 MR. MACLEOD: You are referring to  
19 this Drug Index?

20 MR. MADAY: Yes.

21 MR. MACLEOD: Published by the Drug  
22 Merchandising?

23 MR. MADAY: Yes, which is just a  
24 compilation compiled and also the fact that the pharma-  
25 cist would have the reference texts that are outlined  
26 in our Act.

27 MR. MACLEOD: My point is that these  
28 books would be quite suitable for the older drugs  
29  
30



1 but wouldn't have recent information about the recent  
2 drugs in them for some considerable time.

3 MR. MADAY: That is correct.

4 MR. MACLEOD: I was directing your  
5 attention particularly to the newer drugs, sources  
6 of information about newer drugs.

7 MR. MADAY: Yes.

8 MR. MACLEOD: It would be some time  
9 before these would find their way into official  
10 manuals?

11 MR. MADAY: That is correct.

12 MR. MACLEOD: What does he do in the  
13 meantime, rely on the manufacturers?

14 MR. MADAY: Rely on the manufacturers  
15 and reading other literature that is available to  
16 him.

17 MR. MACLEOD: Do you think most  
18 druggists subscribe to the medical journals?

19 MR. MADAY: No, not most druggists.

20 MR. MACLEOD: Do druggists receive  
21 the same promotional material as a doctor receives?

22 MR. MADAY: I don't know, sir. I will  
23 have to -- of a time, yes.

24 MR. MACLEOD: Would it be fair to say  
25 that most druggists rely on their own - to a certain  
26 extent - on their own trade journals?

27 MR. MADAY: Drug Merchandising, the  
28 Canadian Pharmaceutical Journal, are very necessary  
29  
30





1 and very helpful. As you will notice, they are  
2 compiled by Dr. Hughes of the Ontario College of  
3 Pharmacy who has the compilation of the material in  
4 the Canadian Pharmaceutical Journal.

5 MR. MACLEOD: It gives a very short  
6 monogram on each drug?

7 MR. MADAY: Yes, just a compilation.

8 MR. MACLEOD: Wouldn't that be all  
9 that the druggist would have to go on, plus promo-  
10 tional material from the companies?

11 MR. MADAY: Well, I would think the  
12 person enters into it, sir. I don't know. I imagine  
13 some of them do only use that and have only that but  
14 others actually study and devote quite a bit of time  
15 to these new drugs.

16 MR. MACLEOD: Would it be true to say  
17 a pharmacist who graduated before 1940 would have no  
18 information or knowledge of the tetracyclines only  
19 from what he would pick up from reading journals and  
20 so on?

21 MR. MADAY: Don't forget we have  
22 refresher courses which are sponsored by our Associa-  
23 tion. We travel throughout the Province and we do  
24 bring up the older graduate into the knowledgeable  
25 present. We do receive aid in carrying out this work  
26 from the Foundation of the Canadian Pharmaceutical  
27 Association.

28 MR. MACLEOD: I am just rather disturbed,  
29  
30



1 if I may say so, by this. I am reading from the  
2 March 1961 issue of Drug Merchandising which has  
3 clashes on the cover "New products prescriptions".  
4 "New products proprietary". "New products cosmetics  
5 and toiletries". "New products photographic". "New  
6 products sundries" and so on. It is apparently an  
7 issue devoted to new products. It has this to say  
8 in the paragraph "New products for new profits".  
9

10 "Have you ever lost a sale because  
11 you didn't have the part in stock? Here's your  
12 chance to double-check your shelves for those extra  
13 profit items.

14 On these pages and following you'll  
15 find what's new from prescriptions specially to  
16 drugstore sundries. Products introduced during the  
17 past six months and products about to break to the  
18 retail trade are included.

19 Take a few minutes from your busy  
20 schedule now to check which products you should be  
21 selling for extra profits".

22 That is the introduction. The  
23 following are prescription specialties which would  
24 seem to indicate that the editors of this magazine,  
25 at least, feel they must list the new prescription  
26 products for the information of druggists and suggest  
27 them or appraise them on the benefit of profit.  
28

29 MR. MADAY: Obviously Drug Merchandi-  
30 sing try to sell their own list. This list had been



1 given to them by someone in good faith, perhaps Dr.  
2 Hughes gave it to them. He had of course no control  
3 of what went on top. Since these are official publi-  
4 cations, I don't know how I can answer that.

5 MR. MACLEOD: Will you agree with me  
6 that the whole tenor of the trade magazines is towards  
7 profit and the commercial aspects of drugstores?  
8

9 MR. MADAY: The majority of it, yes.

10 MR. MACLEOD: The majority of it. For  
11 instance, we have another entire issue of August 1960  
12 of Drug Merchandising devoted to discount stores and  
13 asks "Are they a threat to the retail pharmacy?" I  
14 think that is sufficient on that.

15 Now, one small point I want to raise  
16 with you in connection with the table of prescriptions  
17 wherein it is shown that 129 prescriptions required  
18 compounding by the pharmacy. I understand that the  
19 prescription business of the average drugstore would  
20 run something between 20 and 30%.

21 MR. MADAY: That is correct.

22 MR. MACLEOD: So that the compounding  
23 is very small in proportion to the overall volume  
24 of business done in the drugstore?

25 MR. MADAY: That is right.

26 MR. MACLEOD: Do you think it is a  
27 waste of facilities to have a dispensary in every  
28 drugstore? When they are used - actually used in  
29 compounding prescriptions for such a small part of  
30



1 the time in such a small proportion of the business?  
2 For instance, I know that health is involved here and  
3 all that but is it not parallel to the situation where  
4 supposing the law required every service station that  
5 sold gasoline to be completely outfitted to make any  
6 repairs on cars. Isn't that what we are doing here?

7 MR. MADAY: No sir. It wouldn't be a  
8 drugstore if the pharmacist wasn't there so it would  
9 be necessary that a pharmacist be there and that the  
10 drugstores have a prescription department.  
11

12 What you are basically trying to esta-  
13 blish is, I guess, the fact that in our way of living,  
14 our social standard demands that we have medication  
15 available locally, I would say yes. This is a neces-  
16 sary evil.

17 MR. MACLEOD: Wouldn't it be a great  
18 public saving in the long run to everybody if there  
19 were only five or six dispensaries in the city that  
20 could be kept reasonably employed at this work all the  
21 time? Perhaps it wouldn't even need to be five or six,  
22 and the remaining pharmacists would not have to put in  
23 the capital outlay to set up a dispensary or keep a  
24 full-time pharmacist on duty all the time? Could not  
25 a saving be made that way?  
26

27 MR. MADAY: It would be taking away  
28 free enterprise first, which is a very important thing  
29 in our stature. Possibly what you are maybe trying  
30 to relate is the fact that in European countries that



1 this exists or is that what is on your mind?

2 MR. MACLEOD: No. I am not suggesting  
3 that. How many drugstores are there in Calgary?

4 MR. MADAY: 120 - 118.

5 MR. CAMERON: 89.

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MR. MACLEOD: So that you have 89 completely set up units to do dispensing, whereas the actual service is an extremely small part of the business, and perhaps two or three could do the job?

MR. MADAY: That is the compounding, yes. The amount of the compounding is due to the present prescribing practices of the doctor.

MR. MACLEOD: Isn't it also due to the nature of the new drugs, that it is rather impracticable to compound them at the pharmacist's level?

MR. MADAY: No, I think you are referring to the fact that some of these are very potent steroids and such, and are made available as such, but there are other compounds which could be compounded by the pharmacist rather than by the manufacturer.

MR. MACLEOD: So that if the practices of the doctors changed, the work of compounding could increase?

MR. MADAY: That is right. That is the basis of the teaching at the University Hospital. We try to make the interne or the doctor aware of what is in the preparation, and let them go ahead.

MR. MACLEOD: Nevertheless, the general trend has been for a smaller and smaller amount of compounding in the pharmacy?

MR. MADAY: That is right.

MR. MACLEOD: You mentioned that certain





1 preparations bear a stamp: "For therapeutic use only"?

2 MR. MADAY: That is right.

3 MR. MACLEOD: But they are still non-  
4 prescription items?

5 MR. MADAY: Yes.

6 MR. MACLEOD: Would you sell them to  
7 a person who inquired from you what would be a good  
8 medicine to take for a certain condition?

9 MR. MADAY: No sir.

10 MR. MACLEOD: Would you sell thera-  
11 peutic vitamins to anyone who told you they were run  
12 down?

13 MR. MADAY: No sir.

14 MR. MACLEOD: You wouldn't sell any-  
15 thing marked: "For therapeutic use only", except on  
16 a prescription?

17 MR. MADAY: No, if I would have liberty,  
18 if a patient asked me for the product I can sell it,  
19 but I cannot advertise it.

20 THE CHAIRMAN: Do you wish to add any-  
21 thing further yourself, Mr. Maday, or have you pretty  
22 well exhausted what you have?

23 MR. MADAY: Yes I have.

24 MR. FRAWLEY: If I might be allowed at  
25 this point just to read into the record one paragraph  
26 from the Green Book in view of what my friend Mr. Hume  
27 said in commenting on my remarks on Stelazine and  
28 Trilafon. It is paragraph 363 on page 195: "An  
29  
30



1 interesting point is that it apparently does not cost  
2 much to prepare the tablet dosage form".

3 This refers to Trilafon.

4 "Schering buys the bulk drug from its  
5 parent at \$1.96 per gram. It also buys tablets at  
6 various prices; if the 8 mg. tablets are taken as an  
7 example, the price is \$17.72 per thousand. One  
8 thousand 8 mg. tablets would total 8 grams so that  
9 the theoretical cost of the basic drugs in the  
10 tablets would be \$15.68. There is no way of knowing  
11 whether the U.S. parent company takes the same markup  
12 on the drug as on the finished tablets; however, it  
13 is supplying the Canadian company with the basic drug  
14 at \$15.68 and the same quantity of the drug in pre-  
15 pared tablets at \$17.72".

16  
17 I simply thought, Mr. Chairman, it was  
18 appropriate that that should be in the record at this  
19 place really in fairness to the Director's report  
20 itself.

21 MR. HUME: So that the Commission or  
22 Mr. Frawley are not under a misapprehension, I did  
23 not indicate that it was any other way. My point was  
24 that Mr. Frawley, in cross-examining, said that when  
25 the product arrived at the door there was a series of  
26 items that go on, as my learned friend would know if  
27 he were in private practice, there are certain over-  
28 heads, taxes and light, etc. When he used the words  
29 manufacturer's costs maybe thirty times in the  
30



1 transcript, that he is taking into account other  
2 costs.

3 MR. FRAWLEY: Let the record show  
4 that I was only referring to the costs in the Green  
5 Book. I was quite well aware of those other costs  
6 my friend is talking about.

7  
8 THE CHAIRMAN: We only want to get at  
9 the facts.

10 MR. CARIGNAN: Mr. Maday, at page 6  
11 of your brief it is said: "The choice being the  
12 pharmacist's, he would probably choose to dispense  
13 a product which in his experience has proven to be  
14 efficient, stable and competitive, and had been  
15 manufactured by a firm whose integrity and reputa-  
16 tion was beyond reproach". In answer to a question  
17 from Mr. Hume, you said I think that even if the  
18 physicians had been obliged to prescribe by generic  
19 names, the percentages appearing at the foot of page  
20 4 would not have been adequate. You mean by that  
21 that 89% of prescriptions anyway would have been  
22 filled by using brand names? Does it mean that in  
23 your opinion the manufacturers of brand name products  
24 are more likely than the manufacturers of generic  
25 products to fulfill the canons set out in page 6,  
26 these canons being efficiency, stableness, competi-  
27 tiveness, integrity and good reputation. That is  
28 what you meant?

29  
30 MR. MADAY: Yes, I am responsible for



1 what I give out and if I would give out something  
2 of which I don't know, I would be liable for it, so  
3 therefore I have to give out the medication when  
4 ordered by generic name, I have to know it is good.  
5 My reputation is staked on it, so therefore I would  
6 turn to someone I know. I don't know Empire or  
7 Dominion. When Empire's advertising came across my  
8 desk, that was the first I knew of it. I would  
9 certainly have no faith in buying his products. He  
10 may be operating in the basement of a warehouse.  
11 Until I know and am satisfied, I would use my judg-  
12 ment.  
13

14 MR. FRAWLEY: If it was marked:  
15 "Canada approved", that would make all the difference  
16 in the world?

17 MR. MADAY: That would make a big  
18 difference. It would take it off my shoulders.

19 THE CHAIRMAN: Thank you Mr. Maday.  
20 We will adjourn until 2.15.  
21

22 --- The hearing recessed until 2.15 p.m.  
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--- On resuming at 2.15 p.m.

THE CHAIRMAN: Mr. Romaine.

MR. ROMAINE: Thank you, Mr. Chairman.

Mr. Chairman; members of the Commission: The following submission is intended to supplement another document which is being submitted for your perusal. I refer to the reprint of the series of articles, "The Truth About Drug Prices", published in The Albertan in January of this year and subsequently republished in the following papers: The Victoria Times, The Winnipeg Free Press, The Brandon Sun, and The Ottawa Journal.

I trust that it will not be necessary for me to read this series to the Commission, though I would be pleased to do so if the Chairman or other members of the Commission so desire.

THE CHAIRMAN: We have read it, Mr. Romaine. There will be no need for you to.

Before proceeding I would like to apologize for the absence of classification in the material that follows. My excuse (and I hope it will be considered a valid one) is that the material is too diverse to permit classification.

This document is a sort of collection of loose ends that occurred to me personally and came to us directly or indirectly following the publication of this series. I would have liked to classify



1 it but as I said it seemed too diverse to do that.  
2 I would have ended up with more classification  
3 headings than material.

4 I would like to begin by referring to  
5 the brief submitted to this Commission by the Govern-  
6 ment of Alberta last Monday. As you will recall,  
7 the brief suggested that the Commission should look  
8 into the possibility of changes in federal and pro-  
9 vincial legislation which would permit a pharmacist  
10 to dispense a generic drug even when a trade name  
11 drug is mentioned on the prescription unless the  
12 doctor specifically states that only the trade name  
13 drug is to be provided. It may interest this Commis-  
14 sion to know that during our research into drug  
15 prices last fall Mr. Pulford, Ted Pulford (former  
16 city editor of The Albertan) and I found a number of  
17 doctors and pharmacists who favored such a change in  
18 legislation on the grounds that it would enable drug-  
19 gists to stock and dispense generics in quantity,  
20 thereby reducing the cost of prescription drugs on  
21 the retail level.

22 This is not to suggest that pharma-  
23 cists as an organized group would be in favor of such  
24 a change. As a matter of fact both the Alberta Pharma-  
25 ceutical Association and the national association  
26 have indicated through Don Cameron, registrar of the  
27 Alberta Association and Mr. Don McKeague, president  
28 of the national association that they were not in  
29  
30





1 favor of widespread dispensing of generics.

2           Once again if I may get away from  
3 the brief, this brief was prepared subsequent to the  
4 release of the Pharmaceutical Association brief.  
5 We gathered from conversations with Mr. McKeague  
6 and Mr. Cameron that the Association would be opposed  
7 to the dispensing of generics, however, I noticed  
8 the brief does not go quite to that extent but on  
9 the contrary it suggests under certain circumstances  
10 that generics might be acceptable to the retail phar-  
11 maceutical industry. I would like to back-track a  
12 bit on that point. As I say this conversation with  
13 Mr. McKeague and Mr. Cameron occurred early this year.

14           However, in the course of discussions  
15 with about a score of doctors and pharmacists we did  
16 find several who didn't see eye-to-eye - once again,  
17 I am sorry but I must point out we spoke to the  
18 Medical Association at that time and they were opposed  
19 to the idea of generics. We spoke to the head of the  
20 Alberta College of Surgeons yesterday and he indicated  
21 the Association wouldn't take a stand on the matter  
22 of generics, a public stand. ...who didn't see eye-  
23 to-eye with their organizations on this point and who  
24 stated that they would gladly stock generics if the  
25 law permitted them to substitute generic drugs for  
26 brand name products. As a matter of fact one of Cal-  
27 gary's better known and more successful retail drug-  
28 gists is himself a heavy user of generic drugs.  
29  
30



1 I can provide the name of this gentle-  
2 man to the Commission in confidence.

3 THE CHAIRMAN: I was going to say, Mr.  
4 Romaine, a great deal of what is in the brief and  
5 also in the articles would be classed as hearsay and  
6 the Commission wouldn't be in the position to make  
7 any significant use of it except to the extent it is  
8 verified from other sources.  
9

10 MR. ROMAINÉ: I understand.

11 THE CHAIRMAN: It is hearsay and  
12 there is no opportunity of discussing the matter  
13 with the person who made the statement. We don't  
14 know who he is.

15 MR. ROMAINÉ: Let me ask if I can  
16 provide the names and sources, would it be kept in  
17 confidence? It was given to us in confidence.

18 THE CHAIRMAN: I don't think we  
19 would want to disclose the names. If we are writing  
20 reports generally speaking we do not make a habit  
21 of disclosing the names although sometimes it is  
22 necessary to do so.

23 MR. ROMAINÉ: What would be the  
24 best way to provide the names to the Commission?

25 THE CHAIRMAN: You could do it by  
26 letter.  
27

28 MR. ROMAINÉ: Very good, I will.

29 MR. HUME: May I point out the big  
30 problem in that procedure as Your Honour has



1 indicated there is a great many vague hearsay state-  
2 ments and merely to take the name does not provide  
3 anybody with the opportunity of finding out whether  
4 the conversation really took place, merely to write  
5 in a list of names. It seems to me the same objec-  
6 tion you have already made even if there is a name  
7 attached the person is not saying this is what I  
8 said and these are the reasons I said it.

10 THE CHAIRMAN: What the Commission  
11 had in mind and I think Mr. Romaine also, was to  
12 have something to follow up.

13 MR. ROMAINÉ: Mr. Chairman, I was  
14 also going to mention if you wish Mr. Pulford and I  
15 would get the Commission the names and verification  
16 of statements in the form of affidavits. We would  
17 be willing to go on oath in this matter.

18 THE CHAIRMAN: Actually where you are  
19 quoting what people have told you we would want the  
20 affidavit taken by them and not by you.

21 MR. ROMAINÉ: Certainly.

22 This man told us that he has been on  
23 a certain pain-killing drug for several years. When  
24 we asked him whether he used a brand name or generic  
25 product he said, "Generic, of course".

26 As a matter of fact he added, do you  
27 think I am silly. That is neither here nor there.

28 He said that the generic tablets he  
29 requires cost him "a couple of dollars a day",  
30



1 whereas the brand name equivalent would cost about  
2 \$10 per day. Ironically, this man does not stock  
3 generics for resale. When we asked him why he  
4 didn't, he said, "The doctors won't prescribe them.  
5 Not because they don't trust them but because most  
6 of them just don't know the generic names for most  
7 modern drugs".

8  
9                   This same druggist, incidentally,  
10 had some unkind things to say about a good percentage  
11 of his fellow retail pharmacists. He said that they  
12 had been "brainwashed" by the drug manufacturers.  
13 He also told us that another factor in the retail  
14 druggists resistance to generics was the profit  
15 motive. He pointed out that if druggists switched  
16 to generics they would have to raise their mark-up  
17 (which presently varies from 35 to 50 per cent on  
18 most items) to 100 per cent or more in order to main-  
19 tain their current profit margin. When we told him  
20 we thought the public might accept the idea of a  
21 higher profit margin if it meant cheaper drugs he  
22 replied, "Well, most pharmacists don't want to take  
23 that chance. And why should they? They like the  
24 present arrangement".

25  
26                   One of the physicians we interviewed  
27 said he and several colleagues had devised a method  
28 of easing the drug price burden for their poorer  
29 patients. They order generic drugs, in quantity,  
30 from a generic house in Switzerland and resell them



1 at cost to their needy patients. This is done only  
2 in the case of long-term users. The doctor in ques-  
3 tion told us that he regularly imports an arthritic  
4 specific at a third of the Canadian price.

5 Once again if I may get away from  
6 the brief, the logical question is why can't he buy  
7 this particular drug from a Canadian generic house?  
8 The answer to that is that this particular doctor  
9 went to Gilbert and Gilbert unfortunately does not  
10 stock this particular product. There was no generic  
11 alternative to this particular drug.

12 This doctor said he has no objection  
13 whatever to generic drugs. He usually prescribes by  
14 generic name. I'll admit that he's something of a  
15 rarity, in that he knows the generic names of most of  
16 the newer drugs.

17 Once again the reason I think that he  
18 knows more about prescribing by generic names is he  
19 has recently returned from Scotland where he had been  
20 for several years and I believe the generic designa-  
21 tion is more commonly used there than in Canada.

22 I should mention in passing that this  
23 particular doctor told us that the flow of promotion  
24 material from the drug houses is excessive. When we  
25 told him that we had read that an English doctor had  
26 received 111 pounds of promotional material in a  
27 single year, he chuckled and said, "Well, you know  
28 the English are a pretty reserved lot. I'm sure that  
29  
30





1 I receive twice that amount". And I'm sure he meant  
2 it. On the day we visited him he had filled a waste  
3 basket with promotion material. Now, I know enough  
4 about the printing business to be able to say that  
5 brochures are expensive, and I mentioned this, where-  
6 upon he said, "Well, not nearly as expensive as the  
7 sampling conducted by the drug companies". He then  
8 told us that he receives about \$2,500-worth of samples  
9 from drug companies each year, and that if you multiply  
10 this amount by the number of doctors in Canada you come  
11 up with a fantastic cost figure. These promotional  
12 costs are of course reflected in the price of drugs  
13 to the consumer.  
14

15 This same doctor -- and I should men-  
16 tion at this point that he is a specialist in surgery  
17 and a member of what we newspaper people call 'the  
18 silk stocking crowd' - in that he had a high class  
19 clientele - also felt that most doctors had lost  
20 contact with generic names and for this reason  
21 commonly prescribed by brand designation. He also  
22 felt that most doctors had no conception of retail  
23 drugs prices. He subsequently proved this to our  
24 satisfaction by conducting a survey. He asked five  
25 of his colleagues to estimate the retail cost of a  
26 month's supply of a certain drug and found that the  
27 estimates ranged from \$1.50 to \$4.00. Actually, the  
28 drug, in the specified quantity, cost about \$10.00.  
29 This particular doctor's point was that members of  
30





1 his profession should (a) acquaint themselves with  
2 the generic names of drugs, and (b) acquaint them-  
3 selves with the financial burden they place on their  
4 patients when they prescribe drugs.

5 I would like to return momentarily to  
6 the subject of the pharmacist and the generic drug.

7 I must confess that I can't under-  
8 stand the rather violent opposition - I should say  
9 determined opposition - of the retail drug industry  
10 to the generic houses. Although the profit motive  
11 which I previously mentioned may indeed be a factor,  
12 I rather suspect that the so-called "ethical"  
13 industry's promotion onslaught is primarily respon-  
14 sible.

15 In the past few months I have listened  
16 to, or read, the speeches of a number of propagan-  
17 dists for the ethical drug industry. I call them  
18 propagandists because basically their function has  
19 been to propagandize the "ethical" drug industry.  
20 In practically every case these speeches have been  
21 devoted to the condemnation of the generic drug  
22 industry and have been heavily-larded with references  
23 to drug "counterfeiters"; "unethical operators", etc.  
24 Practically every speech I have heard or read in  
25 this connection has been calculated to convey the  
26 impression that the generic drug industry is made up  
27 of "bathtub" operations; i.e., unscrupulous, grubby  
28 little companies who are out to sell shabby imitations  
29  
30



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1 of reputable products and profit at the expense of  
2 the public welfare.

3                   Well, to the best of my knowledge,  
4 such operations do not exist, at least not in  
5 Canada. I have been given to understand that there  
6 is only one generic drug manufacturer in this  
7 country - as distinct from a distributor - Jules R.  
8 Gilbert Limited of Toronto. Significantly, this  
9 company has never been mentioned by name in any of  
10 the anti-generic blasts that I've heard or read.  
11  
12  
13  
14 -  
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1                   What it amounts to is that the  
2 "ethical" drug industry maintains a constant attack  
3 on Gilbert without every mentioning him. In short,  
4 they have managed to malign this man and his company  
5 without putting themselves in a position where they  
6 might have to back up their comments in court.  
7

8                   Mr. Pulford and I went to considerable  
9 lengths to check on Gilbert and we were forced to  
10 conclude that his company is a respectable one.  
11 Fact is, it must be respectable and responsible to  
12 survive in the cut-throat atmosphere in which it  
13 operates. There isn't a so-called "ethical" manufac-  
14 turer in Canada who isn't anxious to have Gilbert's  
15 corporate throat cut.  
16

17                   THE CHAIRMAN: I ask you on the side,  
18 how you can cut a corporate throat?  
19

20                   MR. ROMAIN: I think that is literary  
21 licence, sir.  
22

23                   We established to our satisfaction  
24 that practically every new product manufactured by  
25 Gilbert is immediately seized upon by some member of  
26 the "ethical" drug industry and rushed off to the  
27 food and drug people in Ottawa for analysis. Occa-  
28 sionally this interest in Gilbert's products  
29 reaches amazing proportions. Not long ago, for  
30 example, the food and drug people received six  
samples of a single Gilbert product in one week.  
The samples had been sent in by six different



1 "ethical" companies, each anxious to find something  
2 wrong with the product.

3 If I may go away from the brief again,  
4 Gilbert told me personally that there are times when  
5 he doesn't bother sending any of his samples there.  
6 They are there anyway. They are sent in by the other  
7 companies.  
8

9 THE CHAIRMAN: Did you get this infor-  
10 mation about samples being sent in from Mr. Gilbert?

11 MR. ROMAINE: No, we got that from the  
12 Food and Drug Directorate.

13 THE CHAIRMAN: You got that from the  
14 Food and Drug Directorate?

15 MR. ROMAINE: Yes. It was obtained by  
16 one of our Ottawa correspondents.

17 As Gilbert put it to us, "When it  
18 comes to quality control our system has to be air  
19 tight. We couldn't afford to slip up because the  
20 "ethical" companies would be on us like a pack of  
21 wolves".

22 I gather that Gilbert imports most of  
23 his raw material from European countries, where  
24 generic drugs hold sway. One of the "ethical" indus-  
25 try's complaints is that these materials often come  
26 from "unknown" sources. Gilbert's reply -- and I  
27 think it is a very sound one -- is that he subjects  
28 to careful analysis every bit of material that he  
29 imports. In addition, he chooses his sources  
30



1 carefully, generally buying from the better known  
2 manufacturers.

3 We got a list of half-a-dozen European  
4 companies from whom Gilbert regularly buys most of  
5 the material. I had a member of the ethical pharma-  
6 ceutical industry in this country give an opinion as  
7 to the size and respectability of those companies.

8 We were told they were all well-known  
9 and all quite respectable.

10 It should be pointed out that though  
11 the "ethical" industry condemns the generic industry  
12 because the latter buys much of its raw materials  
13 from generic manufacturers in Europe, the "ethical"  
14 industry frequently does precisely the same thing.  
15 We know of several cases of large-scale importation  
16 of generic products by Canadian and U.S. companies.

17 Now, for sources I am referring to the  
18 Kefauver record. It shows that American ethical  
19 companies do import a substantial amount of raw mate-  
20 rial from the European companies.

21 Before moving on, I would like to  
22 assure this Commission that I do not hold any brief  
23 for Gilbert. He's well-able to defend his own opera-  
24 tion and I'm sure that he'll do this when this Commis-  
25 sion visits Toronto. But I felt that some of the  
26 material we obtained as a result of our discussion  
27 with Gilbert and his people was worth passing along.

28 As you know, many Canadian doctors  
29  
30



1 have expressed concern over the number of prescrip-  
2 tions which go unfilled in this country. I believe  
3 the commonly quoted figure is 40 per cent of all  
4 prescriptions issued.

5 THE CHAIRMAN: I wonder if you could  
6 give us the source of that 40% or 50%. 50% is  
7 mentioned in the next sentence.

8 MR. ROMAINE: Yes. The 40% was a  
9 statement that was raised by a Member of Parliament.  
10 I believe it was Frank Howard. It went uncontested  
11 by the drug industry and the retail pharmaceutical  
12 industry.

13 THE CHAIRMAN: You don't know from  
14 what source he got that information?

15 MR. ROMAINE: I believe he referred  
16 to some research conducted by interested parties. I  
17 would have to go back in our news files to check on  
18 the source.

19 THE CHAIRMAN: This is a statement  
20 which we have not had previously, as far as I can  
21 recall, that anything like 40% or 50% of prescrip-  
22 tions written by physicians were not filled and  
23 there may be some significance attached to that.

24 In order to use it, we would like to  
25 be sure we have accurate information so that we need  
26 to know upon what sort of research this statement  
27 was based.

28 I wonder if you could assist us?  
29  
30





1 MR. ROMAINE: I would be delighted to  
2 track back the sources and confirm it was Mr. Howard.  
3 I believe it was and I will write to him and ask him  
4 if he would be good enough to state his sources  
5 specifically.  
6

7 We asked a Calgary doctor about this,  
8 and he said he would place the figure at 50 per cent.  
9 I wonder if it has occurred to the drug industry --  
10 both the manufacturer and the retailer -- that this  
11 condition -- I'll call it a consumers' strike for lack  
12 of a better description -- is depriving the drug indu-  
13 stry of revenue which could be used to reduce prescrip-  
14 tion costs. In short, wouldn't the industry be well  
15 advised to lower its costs to expand its sale and, in  
16 this way, maintain its present profit levels while  
17 giving the consumer a break?

18 The doctors we interviewed in the  
19 course of our study indicated that, unfortunately,  
20 buyer resistance was strongest among older patients --  
21 the very group to which drugs are particularly impor-  
22 tant. One doctor told us quite frankly that the  
23 mortality rate among his elderly patients is much  
24 higher than it should be, only because of the drug  
25 price factor.  
26

27 If I may leave the brief for a minute.  
28 This particular doctor for a good many years was in  
29 a practice with two relatives, his father, and I  
30 believe, a nephew, and his father was a very elderly



1 practitioner and most of his practice was made up of  
2 elderly people. He had patients of 50 years' standing.  
3 I believe this particular source could speak very  
4 forcibly on this subject, mortality rate among his  
5 patients.

6  
7 He cited the case of a woman patient  
8 who for several months assured him that she was taking  
9 a medication he had prescribed for her. Upon her  
10 death this doctor discovered that she had not taken a  
11 single pill during this period.

12 He checked with the family and asked  
13 them why. They said she just couldn't afford these  
14 pills and the family was in no position to help her.

15 We have in our files numerous letters  
16 from people who reported that they just couldn't  
17 afford the drugs that had been prescribed for them.  
18 Typical of these is a letter from a woman in Rosemary,  
19 Alberta, who told us that she has cancer of the throat  
20 and nose and is on a medication which costs her \$1.50  
21 per day! In her own words, "I'm suffering and I need  
22 the drug. But it would take all of my income to pay  
23 the druggist".

24  
25 Before concluding, in view of the  
26 Alberta Government brief which indicated that some  
27 help was available to this type of indigent patient,  
28 I think in this case it is clear this woman just was  
29 not aware she could go to anyone for assistance. As  
30 a consequence, according to her letter, she does not



1 have the medication she needs.

2 That, Mr. Chairman, completes our  
3 supplementary submission. I would like to thank you  
4 for your kind attention and I stand ready to answer  
5 any question that the Commission or counsel may have.  
6

7 THE CHAIRMAN: There is one point I  
8 would like to make. When you refer to the high cost  
9 of drugs and some people cannot afford to buy them, I  
10 think many of us who have seen the cost of some retail  
11 drugs realise that if people have to take them over a  
12 long period regularly it might be a matter of very  
13 serious financial difficulty for them.

14 Our Commission, of course, this is what  
15 I want to point out, our Commission is not concerned,  
16 under the terms of our statute, with the fact that  
17 the price may be high.

18 What we need to know is why they are  
19 high and whether this is connected with anything that  
20 may come under the heading of monopoly or restrictive  
21 practices. If these are the reasons then we are in a  
22 position to attempt to do something about it.

23 The mere fact that they are high does  
24 not mean that this Commission can provide any remedy.  
25 It may be that they are high because they have to be;  
26 they cost that much to produce. If that is the case  
27 then there is nothing anybody can do anything about  
28 it unless they can find a way of producing them more  
29 cheaply.  
30



1 MR. ROMAINE: I am submitting this  
2 material in the hope that it may be of help to show  
3 one of the reasons drug prices are high in this  
4 country and that is the concerted effort on the part  
5 of the retail pharmacists and drug manufacturers,  
6 the ethical manufacturers, to keep generic products  
7 out of the market.

8 THE CHAIRMAN: Well then, that is  
9 one of the things in which we would be interested if  
10 we have proof of that kind of thing. We would  
11 certainly want to know.

12 MR. ROMAINE: Mr. Chairman, I wonder  
13 should I present a copy of our series to be filed  
14 for the record?

15 THE CHAIRMAN: We all have them  
16 attached to your brief.

17 MR. FRAWLEY: Well, could it go in,  
18 sir, as an exhibit and it could therefore be made  
19 part of the record before the Commission. That is  
20 perhaps what Mr. Romaine intended.

21 THE CHAIRMAN: I do not object to it  
22 being identified as an exhibit. We each have a copy  
23 of it. We will have it available to be looked at  
24 and studied in the sense it may be important to us.

25 MR. FRAWLEY: The witness has read  
26 from what may be called his brief. That is in the  
27 record. Unless this is deemed to have been read and  
28 therefore taken into the transcript, it would just be  
29  
30



1 an extra document.

2 THE CHAIRMAN: It would not appear in  
3 the transcript for anybody to read who is purchasing  
4 the transcript, that is true.

5 MR. FRAWLEY: Unless you wish to take  
6 it in as read - failing that it could be an exhibit  
7 and marked as an exhibit before the Commission.

8 THE CHAIRMAN: We can have it marked  
9 as an exhibit, if that is satisfactory to you.

10 It is headed - it has no date - The  
11 Albertan, Reprint of Albertan Series, The Truth  
12 About Drug Prices. That will be Exhibit C-2.

13 --- EXHIBIT NO. C-2: Reprint from The Albertan news-  
14 paper

15 THE CHAIRMAN: I was going to ask you,  
16 Mr. Romaine, what is your definition of the ethical  
17 drug industry because I think from what you have said  
18 that it could be a little different from what the  
19 Directorate has said when he was referring to the  
20 ethical drug manufacturers in this Green Book, to  
21 which reference has been made.

22 MR. ROMAINE: I think in this case I  
23 put the word ethical in quotations to avoid any  
24 possible confusion. My interpretation of the ethical  
25 drug industry is an industry which produces brand  
26 name pharmaceuticals.



1 THE CHAIRMAN: That is what you mean?

2 MR. ROMAINE: Yes.

3 THE CHAIRMAN: The information we had  
4 was a little different. An ethical drug manufacturer,  
5 as I recall it, reading from the Green Book again, is  
6 a manufacturer of ethical drugs. Ethical drugs being  
7 drugs that are sold on prescription. It did not refer  
8 to the ethics of the manufacturers.

9 MR. ROMAINE: No.

10 THE CHAIRMAN: But to the type of drugs,  
11 where drugs were sold on prescription pretty roughly.  
12 That is it or some modification of that and then these  
13 drugs are called ethical drugs but the manufacturers  
14 of those drugs might make other drugs.

15 MR. ROMAINE: I see, yes.

16 THE CHAIRMAN: There is nothing to  
17 prevent the manufacturer who makes drugs sold under  
18 prescription, which you have described and not with  
19 complete accuracy to our interpretation as ethical  
20 drugs, also manufacturing generic drugs which are  
21 sold under prescription.

22 MR. ROMAINE: Yes, I understand that,  
23 sir.

24 THE CHAIRMAN: I just wanted to make  
25 that point and to be sure I understood what you meant  
26 when you used that term. It seems to be what you  
27 said.

28 Are there any questions?  
29  
30





1 MR. FRAWLEY: I have no questions.

2 MR. HUME: I have some questions.

3 Perhaps, Mr. Chairman, it may be more convenient if  
4 Mr. Romaine and I could face each other so that if  
5 he wants to sit down there is a chair here. I have  
6 not many questions that I would like to ask.  
7

8  
9 CROSS-EXAMINATION BY MR. HUME:

10 MR. HUME: Mr. Romaine, I notice that  
11 in the Exhibit C-2, to which I would like to refer  
12 first, that was put in, these articles were written,  
13 so the masthead indicates, they were prepared by you  
14 and by Mr. Ted Pulford. May I take it from that you  
15 both wrote them or you wrote these articles and Mr.  
16 Pulford did the research or what was the situation?  
17

18 MR. ROMAINE: No, Mr. Hume. We both  
19 did the research and we sat down together and wrote  
20 them.

21 MR. HUME: Is the language used in  
22 these articles his or yours or a combination of both?

23 MR. ROMAINE: A combination of both.

24 MR. HUME: These articles were printed -  
25 there is nothing to indicate on Exhibit C-2 when - I  
26 think my information indicates earlier this year.

27 MR. ROMAINE: Yes.

28 MR. HUME: Early in 1961?

29 MR. ROMAINE: Yes.

30 MR. HUME: I also notice I think that



1 your newspaper indicates as a result of these articles  
2 you started this whole inquiry resulting in the Green  
3 Book. Is this the situation?  
4

5 MR. ROMAINE: No, not the whole inquiry  
6 started in the Green Book. That is your interpreta-  
7 tion, sir. Our interpretation is that this lent some  
8 support to the idea of public hearings across Canada.

9 MR. HUME: Now, Mr. Romaine, these  
10 articles were printed - I presume they were in your  
11 newspaper. Did they appear on consecutive days or  
12 weeks?

13 MR. ROMAINE: Consecutive days.  
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29 -  
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(Hume)

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1 MR. HUME: So that they were all pre-  
2 pared, I presume, at the one time and released on  
3 consecutive days?  
4

5 MR. ROMAINE: Yes.

6 MR. HUME: From what you told me in  
7 the hallway, I understand Mr. Pulford is no longer  
8 with you. Where is he now?  
9

10 MR. ROMAINE: With one of our other  
11 papers in Victoria.

12 MR. HUME: May I suggest to you that  
13 what I would consider the rather extreme and intem-  
14 perate language in some of these articles was really  
15 designed to build circulation for your newspaper,  
16 rather than to make recommendations?

17 MR. ROMAINE: I think you have pro-  
18 bably read the pharmaceutical journals --

19 MR. HUME: No I haven't.

20 MR. ROMAINE: Well, the extreme and  
21 intemperate language is rather obviously calculated  
22 to beat down newspaper opposition.

23 MR. HUME: You are the managing edi-  
24 tor of this newspaper, and I know of it and I have  
25 read it over the years when I have been in Calgary,  
26 and I would consider it with respect extreme language  
27 to refer to a 200 and some odd manufacturers as the  
28 burglars, without qualifying which ones you mean,  
29 just castigating an entire responsible industry as  
30 burglars. Would you not consider that extreme?



1 MR. ROMAINE: No, I think the public  
2 realise we are not using the term literally.

3 MR. HUME: It will sell newspapers,  
4 won't it?

5 MR. ROMAINE: I couldn't tell you. I  
6 am not in the circulation department of the newspaper.

7 MR. HUME: But you are the managing  
8 editor. Do you know what the circulation is?

9 MR. ROMAINE: Yes.

10 MR. HUME: Did the circulation go up  
11 the week after you printed these articles?

12 MR. ROMAINE: I couldn't be sure. I  
13 don't know.

14 MR. HUME: May I suggest to you that  
15 when you use racial discrimination you are being  
16 somewhat extreme?

17 MR. ROMAINE: No, I don't think so.  
18 This was a statement made by a fairly prominent  
19 retail pharmacist. His objection to Mr. Gilbert  
20 appeared to be on racial grounds.

21 MR. HUME: What made you assume that  
22 I was talking about Mr. Gilbert?

23 MR. ROMAINE: That is the only time we  
24 used the reference to racial discrimination. I think  
25 there is one other brief reference about European  
26 drugs which touches on the racial angle.

27 MR. HUME: Your quotation refers to an  
28 industry spokesman referring to the attitude of the  
29  
30



1 ethical industry. Are you referring to the pharma-  
2 ceutical retailers or the manufacturers, or do you  
3 care to which you refer as long as you take a slap  
4 at somebody?

5 MR. ROMAINE: I certainly do care. I  
6 like to take a slap at the right person.

7 MR. HUME: Chapter 2, about eight  
8 inches down: "One industry spokesman summarized  
9 perfectly the attitude of the 'ethical' industry --"  
10 What industry are you talking about?

11 MR. ROMAINE: The brand name drug  
12 industry.

13 MR. HUME: The manufacturers or  
14 retailers, or both?

15 MR. ROMAINE: Unfortunately we felt  
16 the two were so closely tied together they are indis-  
17 tinguishable.

18 MR. HUME: So you are talking about  
19 the pharmacists and the manufacturers?

20 MR. ROMAINE: Yes.

21 MR. HUME: How do you figure that the  
22 comment referring to Mr. Gilbert, who I have met and  
23 probably is, as you suggest, a Jewish gentleman,  
24 what attitude are you trying to summarize, racial  
25 discrimination?

26 MR. ROMAINE: Yes sir. As a matter  
27 of fact a half-a-dozen druggists that we talked to  
28 made slighting remarks about Mr. Gilbert because of  
29  
30



1 his nationality -- religious background.

2 MR. HUME: So that what you are trying  
3 to tell your readers there is that whatever else is  
4 of any value in this article, that the whole ethical  
5 pharmaceutical industry believes a man no good  
6 because he is of a religion other than their own?

7 MR. ROMAINE: I believe that the  
8 people in the drug industry do go out of their way  
9 to damage this man.

10 MR. HUME: Who told you that; Mr.  
11 Gilbert?

12 MR. ROMAINE: Mr. Gilbert plus some  
13 doctors.

14 MR. HUME: Mr. Gilbert operates in  
15 Toronto, and this evidence has been made public and  
16 given to the Ontario Select Committee. He operates  
17 a perfectly proper manufacturing industry?

18 MR. ROMAINE: Yes, but unfortunately  
19 the industry won't acknowledge that publicly.

20 MR. HUME: Is this your opinion?

21 MR. ROMAINE: No, I have read enough  
22 pharmaceutical journals, talked to enough detail men,  
23 to know that this man is never acknowledged as being  
24 respectable. This is the first time I have heard  
25 anyone in the industry say he runs a respectable  
26 industry.

27 MR. HUME: Do you mean nobody ever  
28 indicated to you that this and other, you say in  
29  
30





1 your brief, that he is the only generic manufacturer  
2 in Canada. If you had done any research you would  
3 have found there were others. Did everybody you  
4 talked to say because he is a Jew and from Toronto  
5 his products are no good?

6 MR. ROMAINE: No, what I am implying  
7 is that each time the name was brought up, more or  
8 less in defence of their boycott on this man, the  
9 druggists said he is just a sharp operator, a shyster.  
10

11 MR. HUME: These are druggists that  
12 say this?

13 MR. ROMAINE: Yes.

14 MR. HUME: So that you now condemn the  
15 entire ethical industry. How many druggists would  
16 say that to you out of the 89 in Calgary?

17 MR. ROMAINE: Half-a-dozen dismiss  
18 this man as being a shyster and not worth considering.

19 MR. HUME: Because half-a-dozen out of  
20 89 in Calgary, the hundreds in Alberta, and the  
21 thousands in Canada, you write an article which says  
22 that this typifies the entire attitude of the ethical  
23 industry towards Mr. Gilbert. I suggest to you that  
24 that is intemperate language. Do you disagree or not?  
25

26 MR. ROMAINE: I disagree.

27 MR. HUME: I just wanted to see how  
28 your mind works on the thing. Look at Chapter 4.  
29 You have one, two, three, four, five, six columns over  
30 and about two-thirds down the column in Chapter 4 you



1 are quoting somebody or other: "Here is how the retail  
2 pharmacists aid and abet the profiteer". You don't  
3 think that is intemperate language?

4 MR. ROMAINE: No, I think the profits  
5 of the drug industry are excessive.

6 MR. HUME: Do you know what they are?

7 MR. ROMAINE: I have a fair idea.

8 MR. HUME: What do you think they are  
9 on a national average according to D.B.S. figures?

10 MR. ROMAINE: Unfortunately I am not  
11 a one-man research organization, but I do know that  
12 the profits of the drug industry in the U.S. run 20%.

13 MR. HUME: Are you talking about the  
14 pharmacists or the manufacturers?

15 MR. ROMAINE: The manufacturers.

16 MR. HUME: Did you happen to check D.B.S.?

17 MR. ROMAINE: Unfortunately I am not a  
18 tax expert. However, the figures from the Kefauver  
19 record had been checked and had not been disputed.

20 MR. HUME: I reserve the right to  
21 question that statement. Here is your quote: "Brand  
22 names are your guarantee of quality. Brand name  
23 drugs are safe drugs. What does the price matter;  
24 it's your health that counts".

25 MR. ROMAINE: That is our own quote,  
26 but I think that generally reflects the industry.

27 MR. HUME: So you just put quotes  
28 around it to make it appear as if somebody responsible  
29  
30



1 had said it?

2  
3 MR. ROMAINE: This is what the industry  
4 states in advertising.

5 MR. HUME: I presume this is your  
6 opinion: "What do these slogans imply? They imply  
7 that anything without a brand name is dangerous, or  
8 at least suspect". I suggest they imply no such  
9 thing. That brand names signify quality and this  
10 applies to everything, peaches, toothpaste and auto-  
11 mobiles.

12 MR. ROMAINE: Sir, we are dealing with  
13 inference there. My inference implies a lack of  
14 quality.

15 MR. HUME: I want you to turn to  
16 nearly the end. Here is another quote: "The brand  
17 name manufacturers claim that there is no such thing  
18 as a reputable generic manufacturer. But of course  
19 this is blatant nonsense!" I agree, and I suggest  
20 to you that the brand name manufacturers have never  
21 claimed any such thing, and that this is a pure  
22 invention to sell newspapers.

23 MR. ROMAINE: I have yet to encounter  
24 a case where any spokesman of the various retail and  
25 manufacturing organizations has come out and said  
26 that in certain cases the generic industry can be  
27 fairly reliable and fairly respectable. In nearly  
28 every case the generic industry is condemned and by  
29 implication the whole industry is condemned.  
30



1 MR. HUME: On page 2 of your brief  
2 you are quoting a druggist. You say that his col-  
3 leagues, these responsible people that have two  
4 years of university, and are Bachelors of Science  
5 and Pharmacy have been brainwashed. What druggist  
6 said this?  
7

8 MR. ROMAINE: I have offered to give  
9 the Commission the name. I am certainly not going  
10 to give it to you in the presence of executives of  
11 the Alberta Pharmaceutical Association. I think the  
12 gentlemen in this room know who this particular  
13 druggist is.

14 MR. HUME: I don't. I am a stranger  
15 in the city and I see a quote which to me sounds  
16 like utter nonsense. What did he mean, brainwashed?  
17

18 MR. ROMAINE: He said these people  
19 have fallen for the propaganda of the drug manufac-  
20 turer and have reached a point now --

21 MR. HUME: Had they believed every-  
22 thing you said here, would they have been brainwashed  
23 by The Albertan?

24 MR. ROMAINE: No, because this is one  
25 series of articles, and in the case of the drug manu-  
26 facturer you are dealing with a steady stream of  
27 propaganda.

28 MR. HUME: Quoting your own opinion  
29 on page 4, you say: "I must confess that I can't  
30 understand the rather violent opposition of the



1 retail drug industry to the generic houses". You  
2 are talking there about the pharmacists?

3 MR. ROMAINE: Yes.

4 MR. HUME: "Although the profit  
5 motive which I previously mentioned may indeed be a  
6 factor, I rather suspect that the so-called 'ethical'  
7 industry's promotion onslaught is primarily respon-  
8 sible". By the ethical industry, who do you mean,  
9 everybody, the manufacturers, the retailers, every-  
10 body but Mr. Gilbert?

11 MR. ROMAINE: I mean the manufacturer.

12 MR. HUME: That is not the same sense  
13 that you use the same word in the article?

14 MR. ROMAINE: No, in the case of the  
15 article we are tying the industry together.

16 MR. HUME: You say there is only one  
17 generic manufacturer in the country, Jules Gilbert?  
18 That is not so?

19 MR. ROMAINE: To the best of my know-  
20 ledge it is. I understand Empire is a distributor,  
21 Gilbert is a manufacturer.

22 MR. HUME: Who told you that, did Mr.  
23 Gilbert tell you that?

24 MR. ROMAINE: No, we checked with  
25 doctors and asked them what catalogues they received.  
26 I saw Empire's catalogue and they listed themselves  
27 as a distributor.

28 MR. HUME: On page 5, here is a  
29  
30



1 straight statement of fact by Edward Romaine: "There  
2 isn't a so-called 'ethical' manufacturer in Canada  
3 who isn't anxious to have Gilbert's corporate throat  
4 cut". Where do you get such nonsense as that?

5 MR. ROMAINE: I don't think I have  
6 read of a single case of a brand name manufacturer  
7 coming out with a compliment, with anything which  
8 would indicate approval of Mr. Gilbert.

9 MR. HUME: It seems to me like you  
10 may have been brainwashed by Mr. Gilbert.

11 MR. ROMAINE: I have read statements  
12 issued by the President of your organization in  
13 pharmaceutical journals. Can you honestly say that  
14 any of these statements have indicated that there  
15 may be some good in the generic drug industry?

16 MR. HUME: Have you read the procee-  
17 dings before the Ontario Select Committee when Mr.  
18 Gilbert and others gave evidence?

19 MR. ROMAINE: No.

20 MR. HUME: You say on page 6: "Before  
21 moving on, I would like to assure this Commission  
22 that I do not hold any brief for Gilbert". May I  
23 take it that the only reference you have to Mr.  
24 Gilbert in this thing is because you believe he is  
25 the only so-called generic manufacturer?

26 MR. ROMAINE: No, not particularly.  
27 Mr. Gilbert fortunately is one drug manufacturer who  
28 will list his price in catalogues, which I can  
29  
30





1 readily obtain. I tried to get catalogues from the  
2 ethical companies. I had a very difficult time.

3 MR. HUME: Oh, come, really. You had  
4 a difficult time to get price catalogues?

5 MR. ROMAINE: Yes, from a number of  
6 retail pharmacists, and also from the Alberta Pharma-  
7 ceutical Association, and I didn't get very much  
8 co-operation from Mr. Cameron and Mr. Maday.

9 MR. HUME: Have you read the procee-  
10 dings before this Commission in the preceding weeks?

11 MR. ROMAINE: No I haven't.

12 MR. HUME: Did you read Dr. Morrell's  
13 evidence given in Ottawa about the support of price  
14 given to some importers of generic drugs from Europe?

15 MR. ROMAINE: I have read extracts  
16 from Dr. Morrell's statement in pharmaceutical  
17 journals.

18 MR. HUME: Does it surprise you to  
19 know that Mr. Jules R. Gilbert is an ethical manufac-  
20 turer of drugs in Canada and is just as anxious,  
21 and says so publicly, to sell his brands of generic  
22 drugs as any brand name manufacturer that you  
23 condemn so forcibly? Do you know that?

24 MR. ROMAINE: I do know that he puts  
25 out proprietary medicines, but I was not aware he  
26 puts out prescription drugs.

27 MR. HUME: When he puts out a generic  
28 name with a drug and urges the druggist to sell his  
29  
30



ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Romaine, cr ex  
(Hume)

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1 line, he is selling Gilbert's pharmaceuticals, isn't  
2 he?

3 MR. ROMAINE: I don't think so.

4 MR. HUME: Thank you, you have been  
5 very helpful.  
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FB/dpw

1 MR. FORSYTH: I have a few questions.  
2 I won't be too long on this.

3  
4 Mr. Romaine, one statement you made  
5 that appears to be indicated throughout your article  
6 that is causing me some concern, before you were  
7 examined by Mr. Hume, you stated, in your opinion -  
8 I am not quoting you verbatim - I believe I am adding  
9 nothing to what you said, one cause of concern was  
10 that concerted effort on the part of the retail pharma-  
11 cists and the ethical druggists to restrain the use  
12 of generic drugs; is that more or less your statement?

13 MR. ROMAINE: Yes, I believe that.

14 MR. FORSYTH: You have heard evidence  
15 before this Commission today and I am sure as a  
16 result of your extensive investigation you are aware  
17 of the fact that the pharmacist can only prescribe  
18 and dispense drugs in accordance with the prescrip-  
19 tion that the doctor gives to him and if the doctor  
20 prescribes by brand names he must dispense by brand  
21 names; is that correct?

22 MR. ROMAINE: I am aware of that.

23  
24 MR. FORSYTH: You also heard evidence  
25 this morning approximately 90% of the prescriptions  
26 in Alberta and possibly a higher figure as my friend,  
27 Mr. Hume, brought out in his examination, are pre-  
28 scribed by doctors on brand name basis; is that  
29 correct?

30 MR. ROMAINE: That is right.



1 THE CHAIRMAN: You are not in a posi-  
2 tion to verify it but you can't contradict it?

3 MR. ROMAIN: I was aware this informa-  
4 tion had been provided.

5 MR. FORSYTH: Were you aware of this  
6 information at the time this article was prepared and  
7 written, the information the druggist may only dis-  
8 pense what the doctor orders?

9 MR. ROMAIN: Yes.

10 MR. FORSYTH: You were aware of this  
11 information?

12 MR. ROMAIN: Yes.

13 MR. FORSYTH: Can you explain to me  
14 and I refer you to your series of articles Chapter 1,  
15 the first paragraph where you state - correction,  
16 the fourth paragraph "Your friendly neighbourhood  
17 druggist" - I presume this term is stated in all  
18 sincerity - "could slash his prescription prices  
19 merely by ordering his pharmaceuticals from any of  
20 a score of reputable Canadian, U.S. or European  
21 manufacturers who mass-produce drugs under their  
22 generic names". In light of the fact all the pharma-  
23 cists must prescribe according to what the doctor  
24 prescribes, do you think that statement is an accu-  
25 rate statement?  
26

27 MR. ROMAIN: Yes, I think so, sir,  
28 because basically - I don't think there is much  
29 doubt the pharmaceutical profession could have the  
30



1 type of law in Alberta it wishes. In other words,  
2 the Provincial Government has indicated - did indi-  
3 cate the other day it would be quite prepared to  
4 alter the Pharmaceutical Act to enable the retail  
5 pharmacists to substitute generic.

6 MR. FORSYTH: Are you suggesting at  
7 the time you wrote the articles what you had in mind  
8 was legislation by the Alberta Government to alter  
9 the Act so the pharmacists could dispense generically?  
10

11 MR. ROMAINE: One of our sources, as  
12 a matter of fact the Registrar of your organization,  
13 informed me of the law that prevented these people -  
14 Mr. McKeague and Mr. Cameron...

15 MR. FORSYTH: That is fine. I am  
16 asking if you had in mind this would of necessity be  
17 proceeded by a change of legislation?

18 MR. ROMAINE: The laws would change  
19 if the pharmacists desired and if the medical profes-  
20 sion liked them.

21 MR. FORSYTH: Dealing with the medical  
22 profession, this statement also causes me concern.  
23 I refer you to the last three or four paragraphs of  
24 Chapter 2, the third column over. You say the medi-  
25 cal profession is powerless to prescribe generic  
26 drugs. Surely, sir, you are not suggesting that it  
27 is the medical profession's opinion that it is the  
28 pharmacist that is preventing the medical profession  
29 from prescribing generically?  
30



1 MR. ROMAINE: At that time that was  
2 the indication that had been given to us by the  
3 doctors. They said, blame the druggist. He is the  
4 fellow you have to go after. It isn't us.

5 MR. FORSYTH: Can you give me a rough  
6 idea of how many doctors you talked to that gave  
7 that information?  
8

9 MR. ROMAINE: Well, I would say several  
10 out of possibly ten or fifteen we talked to.

11 MR. FORSYTH: A number out of ten or  
12 fifteen?

13 MR. ROMAINE: I would say several out  
14 of ten to fifteen.

15 MR. FORSYTH: Their attitude is they  
16 can't prescribe generically?

17 MR. ROMAINE: They made the point the  
18 pharmacist does not stock generics.

19 MR. FORSYTH: It is a question which  
20 comes first, the chicken or the egg.

21 MR. ROMAINE: I am afraid so, yes.

22 MR. FORSYTH: One other point, Chapter  
23 4 of your submission - I am merely interested in  
24 establishing for the purposes of the record what  
25 your source is for the figures with respect to the  
26 retail pharmacy you use extensively in that chapter.

27 MR. ROMAINE: The November issue of  
28 the Canadian Pharmaceutical Journal.

29 MR. FORSYTH: September?  
30





1 MR. ROMAINE: November, I believe.

2 That is right, that is the one.

3 THE CHAIRMAN: November of 1960?

4 MR. ROMAINE: September of 1960, I  
5 believe.

6 MR. FORSYTH: That is the source of  
7 the figures entirely in Chapter 4?

8 MR. ROMAINE: On the retail pharmacy.

9 MR. FORSYTH: It was the 18th annual  
10 survey of the Canadian Pharmaceutical Association;  
11 is that correct?

12 MR. ROMAINE: Yes.

13 MR. FORSYTH: The figures you have  
14 used in this Chapter 4 of your statement have been  
15 taken out of this summary?

16 MR. ROMAINE: That is correct.

17 MR. FORSYTH: As the Commissioner has  
18 quite properly pointed out a good deal of your sub-  
19 mission deals with hearsay. I understand you will  
20 furnish the Commission with names. I am not going  
21 to ask you the names, but I would be interested to  
22 know how many pharmacists in the City of Calgary  
23 you spoke to in the course of your investigation?

24 MR. ROMAINE: A dozen.

25 MR. FORSYTH: A dozen. Did you go  
26 elsewhere out of the City of Calgary?

27 MR. ROMAINE: Yes, I went to two  
28 pharmacies in Edmonton.  
29  
30



1 MR. FORSYTH: Two in Edmonton and a  
2 dozen in Calgary?

3 MR. ROMAINE: A dozen in Calgary.

4 MR. FORSYTH: Your source of informa-  
5 tion is fourteen pharmacists in all?

6 MR. ROMAINE: I would think that  
7 would be an accurate guess. It must be remembered  
8 I didn't interview the fourteen personally.

9 MR. FORSYTH: Fourteen were inter-  
10 viewed?

11 MR. ROMAINE: Pulford probably inter-  
12 viewed half of those.

13 MR. FORSYTH: Before the articles were  
14 written in The Albertan were you aware, Mr. Romaine,  
15 of the fact that the Food and Drug Director set out  
16 in the Alberta Pharmaceutical Association submission  
17 cannot pretend under present circumstances to guaran-  
18 tee the quality standards in drugs used in Canada?

19 MR. ROMAINE: If I am not mistaken  
20 that statement was in the September issue of the  
21 Pharmaceutical Journal.

22 MR. FORSYTH: You were aware of that?

23 MR. ROMAINE: Yes, I read it.

24 MR. FORSYTH: I think I have no further  
25 questions.

26 MR. MACLEOD: Just one question: I  
27 gained the impression from certain questions of Mr.  
28 Hume that you had based certain statements on  
29  
30



1 interviews with six druggists in relation to Gilbert.  
2 Did you also talk to detail men in connection with  
3 Gilbert?  
4

5 MR. ROMAINE: Yes.

6 MR. MACLEOD: What statement did the  
7 detail men make to you about Gilbert in his province?

8 MR. ROMAINE: One told us that - if  
9 you want the truth about Gilbert have a look at this  
10 brochure. It contained half-a-dozen pictures of a  
11 drug counterfeiting operation taken somewhere in New  
12 Jersey, showed drugs being manufactured and washed  
13 in the vilest circumstances, dank basement. This  
14 was passed off to us by the detail man as being an  
15 indication of the generic drug industry. I think we  
16 subsequently - Mr. Pulford pointed out in a speech  
17 to a local organization that the picture was a  
18 counterfeiting gang putting out brand name drugs.  
19 They weren't producing generic drugs. They were  
20 counterfeiting a brand name pill. This detail man  
21 based his talk to us as this being the type of opera-  
22 tion Gilbert had.

23  
24 MR. MACLEOD: Was this detail man  
25 representing a firm selling brand drugs?

26 MR. ROMAINE: He was indeed, one of  
27 the major companies.

28 MR. MACLEOD: Mr. Chairman, in the  
29 course of his cross-examination my friend, Mr. Hume,  
30 stated as a fact, put to the witness there were



1 other brand name - other manufacturers of generic  
2 drugs in Canada beside Gilbert. I think if he is  
3 putting that fact into the record he should give us  
4 the name of the manufacturers he was referring to.

5 MR. HUME: I would be glad to. I am  
6 instructed one is Empire. It depends what you mean  
7 by manufacturer. I deem a manufacturer is anybody  
8 that takes a raw product and processes it, puts his  
9 name on it and does something to it. I understand  
10 there are several doing just that. If you mean a  
11 manufacturer has to take a chemical out of the ground  
12 from the very beginning, then perhaps we are not  
13 seeing eye to eye. To me a manufacturer is somebody  
14 who takes a product and bottles it, labels it, tests  
15 it and does what he has to do to it and distributes  
16 it. He is manufacturing pharmaceuticals. I under-  
17 stand there are several companies. I will have to  
18 get this information.

19 MR. MACLEOD: It doesn't matter what  
20 I think, Mr. Hume. If the statement is made that  
21 there are other manufacturers of generic drugs beside  
22 Gilbert in Canada the Commission is entitled to the  
23 names of these. The Commission can then judge if  
24 these, through the nature of their operation, are  
25 manufacturers, whether they will consider them manu-  
26 facturers. I suggest that information having been  
27 put forward should be made more specific and provided  
28 to the Commission.  
29  
30



1 I have a second point along the same  
2 lines. You put it to the witness that there was a  
3 statement about Gilbert being a reliable, ethical  
4 drug manufacturer and the witness said to you he  
5 wasn't aware of such statements. On this point I  
6 find myself in agreement with Mr. Romaine having  
7 read most of the statements I could find from any  
8 source whatsoever. I have been unable to find any  
9 statements by any so-called ethical drug manufacturers  
10 giving Gilbert any credit at all and again, I think  
11 in fairness to the Commission these statements which  
12 you have referred to - the sources of these state-  
13 ments you have referred to should be put on the  
14 record. If the statement is made there are state-  
15 ments to that effect I think the sources should be  
16 given. Those are the only points I have to raise.

17  
18 MR. HUME: I don't know what kind of  
19 answer that calls for. I have heard it said. We  
20 will be making a submission in November. I will read  
21 this in the transcript. Anything that is pertinent  
22 in due course will be put forward if it is material.  
23 If my friend wishes it I will try and find it to  
24 tell him. I know I have heard it.

25  
26 THE CHAIRMAN: What we are concerned  
27 with is getting at the facts. If the facts are as  
28 the witness has stated they are rather different from  
29 what you have been telling us.

30 MR. HUME: Evidence was presented



1 before the Ontario Select Committee by his customers.  
2 No doubt they would say so if I asked them. One  
3 assumes if people in hospitals are buying from him  
4 and they are, there is no question about it, they  
5 regard him in that way.  
6

7 THE CHAIRMAN: The point may be what  
8 is meant by an ethical drug manufacturer, if you are  
9 manufacturing drugs sold under prescription, trade  
10 names or manufacturing prescription drugs sold under  
11 generic names. That is the way we are distinguishing  
12 between ethical drugs.

13 MR. HUME: I beg your pardon, I have  
14 to suggest to you the word ethical as it exists in  
15 the By-Laws, incorporating documents of the Associa-  
16 tion which I represent, is anybody manufacturing  
17 pharmaceutical products sold by prescription.

18 THE CHAIRMAN: That is what I wanted.

19 MR. HUME: It doesn't matter whether  
20 it is generic or trade name. In due course our brief  
21 will be presented with letters patent and its consti-  
22 tution and so on and this will be the way I use the  
23 word as I understand the pharmacists use it in the  
24 trade. It is anybody who is manufacturing pharma-  
25 ceutical products for use, for sale by prescription.  
26 That includes Mr. Gilbert.

27  
28 THE CHAIRMAN: That is the definition  
29 used by the Director in the Green Book. It isn't  
30 the sense it has always been used in our hearing.





1 MR. HUME: I am sorry. I didn't know  
2 that.

3 MR. MACLEOD: I don't want to prolong  
4 this. I do want to make it clear I wasn't criti-  
5 cizing anything my friend, Mr. Hume, had said. It  
6 was merely he had mentioned additional generic manufac-  
7 turers. I think the names should come out. He has  
8 referred to statements which say Gilbert was praised.  
9 I think the sources of these statements should go in  
10 and the Commission can judge for themselves.

11 THE CHAIRMAN: Perhaps Mr. Hume  
12 will be able to give us that in the Fall.

13 MR. HUME: I don't like people putting  
14 words in my mouth. I don't think I said he was  
15 praised. The report will show you how I used the  
16 words. It will be cleared up. As to the names,  
17 from what I understand, Empire Laboratories Limited  
18 is a manufacturer of pharmaceutical products. My  
19 friend has knowledge. He will correct me if I am  
20 wrong.  
21

22 MR. FRAWLEY: Maybe the praise was  
23 the well-known faint praise.

24 MR. HUME: By which one can be easily  
25 damned.  
26

27 THE CHAIRMAN: Thank you, Mr. Romaine.

28 Are there any others here today who  
29 wish to make representations to the Commission?  
30 There were none this morning. Is there anyone here



1 now to make any representations?

2 This will conclude the hearings then.

3  
4 --- Whereupon the proceedings adjourned until July  
5 31st, 1961.  
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INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director Of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	-- Chairman
A.S. WHITELEY, M.A.	Member of the Commission
PIERRE CARIGNAN, Q.C.	Member of the Commission
F.N. MACLEOD	Combines Officer,
representing the Director of Investigation and Research	

Proceedings of hearings commencing at  
10 a.m., Monday, July 31st, 1961, et  
seq, in the City of Vancouver, in the  
Province of British Columbia.



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THE CHAIRMAN: Ladies and gentlemen,  
we are opening this morning the Vancouver hearings  
in the inquiry being conducted by the Restrictive  
Trade Practices Commission into the manufacture,  
distribution and sale of drugs.

We hope to receive representations,  
both by way of written briefs and perhaps by way of  
oral statements, and at the opening this morning,  
we would like to know who are here with the intention  
of making any representations to us.

Mr. MacLeod is appearing and assisting  
the Commission. I understand there are some organi-  
zations who desire to present written briefs and  
have some discussion concerning the matters raised  
in those briefs.

We would like to know who are here.

MR. HINKSON: I appear, Mr. Chairman,  
on behalf of the Pharmaceutical Association.

THE CHAIRMAN: What are your initials?

MR. HINKSON: E.E.

THE CHAIRMAN: For the --?

MR. HINKSON: Pharmaceutical Associa-  
tion.

THE CHAIRMAN: Of B.C.?

MR. HINKSON: Yes, Mr. Chairman. We  
have a written brief which the Registrar of the  
Association will present.

THE CHAIRMAN: Are you counsel for



1 them?

2 MR. HINKSON: Yes, I am, Mr. Chairman.

3 THE CHAIRMAN: Who are appearing with  
4 you?

5 MR. HINKSON: I have with me - Mr.  
6 Chairman, the President of the Association lives in  
7 Revelstoke, British Columbia. He is a retail pharma-  
8 cist there. He is not able to be present, Mr.  
9 Donaldson.

10 I have Mr. Douglas Brown, the Vice-  
11 President of the Association and two of our local  
12 councillors from Greater Vancouver here.

13 As well I have on my left Mr. Hender-  
14 son, who is the Executive Secretary.

15 THE CHAIRMAN: Mr. Henderson's initials  
16 are?

17 MR. HINKSON: G.G., Mr. Chairman.

18 THE CHAIRMAN: Executive Secretary.

19 MR. HINKSON: Of the Association. On  
20 my left, Mr. Douglas Denholm, who is the Registrar  
21 of the Association.

22 THE CHAIRMAN: Are there any other  
23 organizations appearing this morning?

24 MRS. MCGHIE: I am Mrs. A.W. McGhie,  
25 Provincial President of the Canadian Association of  
26 Consumers.

27 THE CHAIRMAN: You have a brief, I  
28 understand?



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MRS. MCGHIE: Yes.

THE CHAIRMAN: Will anybody else be speaking with you or will you be conducting the presentation?

MRS. MCGHIE: I will be taking it myself.

MR. KELLY: W.C. Kelly, for the Federated Legislative Council of Elder Citizens.

THE CHAIRMAN: Are you counsel for the Federation, Mr. Kelly?

MR. KELLY: Speaking for them, yes.

THE CHAIRMAN: Have you any officers of the Association with you who will be taking part in the proceedings?

MR. KELLY: Well, they are here. I do not think they plan to take any part.

THE CHAIRMAN: If they do take any part, we can get their names at that time.

MR. KELLY: Yes. We have a written brief.

MR. LOCKHART: My name is S.M. Lockhart. I would like to address the Commission without a brief. I am speaking only for myself.

THE CHAIRMAN: Yes, Mr. Lockhart. We will call on you when we get to that point.

Are there any others who wish to speak or address the Commission? If not, we had better proceed with the first presentation of which we had





1 information.

2 MR. HUME: May I enter an appearance?

3 THE CHAIRMAN: Yes, I am sorry.

4 MR. HUME: I should like to enter an  
5 appearance. My name is F.R. Hume. I am counsel  
6 for the Canadian Pharmaceutical Manufacturers' Asso-  
7 ciation. With me, from Montreal, is Mr. H.J. Brown,  
8 who is here in his capacity as President of that  
9 Association.  
10

11 MR. MACLEOD: Mr. Chairman, I was  
12 talking to Mrs. McGhie on the 'phone last night and  
13 I indicated to her that her brief would be taken  
14 first. I have not been talking to any other people  
15 or other groups who are represented here and there  
16 is no arrangement been entered into as to the order  
17 after the first brief.

18 THE CHAIRMAN: We will call on Mrs.  
19 McGhie first. I understand and am advised her brief  
20 will be presented at the opening this morning.

21 Will you come forward where we can  
22 hear you better. There is chair in the witness box  
23 if you would like to go in there.

24 MRS. MCGHIE: Mr. Chairman and gentle-  
25 men: For the past several years, the Canadian Associa-  
26 tion of Consumers in British Columbia has received  
27 many enquiries and resolutions regarding the high  
28 cost of drugs to the consumer.  
29

30 Some of these enquiries came from



1 individuals, but many of the resolutions came from  
2 bodies of women affiliated with the Canadian Associa-  
3 tion of Consumers, namely: The Women's Institute,  
4 the Imperial Order Daughters of the Empire, the  
5 Council of Jewish Women and the Provincial Council  
6 of Women. Thus you see that these enquiries repre-  
7 sent the thinking of a large and varied cross-section  
8 of the consumer public. The gist of these enquiries  
9 and resolutions was the high cost of drugs and the  
10 burden these high prices place on the purchaser.  
11 Those most affected were people in the low income  
12 bracket; young couples just starting out in life; and  
13 the retired. The latter, because of age, are parti-  
14 cularly susceptible to degenerative diseases needing  
15 continuous medication.

17           The executive and membership of the  
18 Canadian Association of Consumers were very respon-  
19 sive to the need for lower priced drugs but felt that  
20 they had no machinery to cope with the necessary  
21 investigation to find out whether or not drugs were  
22 unnecessarily high. While realizing fully the worry  
23 and distress caused by these high prices, they knew  
24 that the antibiotics had come into being after long  
25 and costly research. One thing they felt could be  
26 done, and urged the Government to do; was to repeal  
27 the 11 percent Federal Tax on all drugs. This would  
28 be a small help to the overburdened buyer of drugs.

30           Branches of CAC have read available



1 literature; held panel discussions; shown films,  
2 etc. to acquaint themselves with facts relating to  
3 the drug industry.  
4

5 It was very enlightening to the CAC  
6 membership to find out that the process for making  
7 these new ethical drugs was patented and that Canada  
8 was dependant on securing these drugs from the USA  
9 at a patented price. The Kefauver Investigation in  
10 the United States was followed with keen interest by  
11 the members and they were much concerned to learn  
12 that many of the facts brought out by this investiga-  
13 tion were applicable to Canada as well.

14 We, therefore, welcome the Government's  
15 decision in appointing a commission to investigate  
16 the cost of drugs to see how they can best be made  
17 available at lower prices to the consumer.

18 In the days before the discovery of  
19 insulin, the sulfonamides and antibiotics, medicines  
20 were very largely ameliorative, but now-a-days often  
21 take the place of some vital function of the body,  
22 (e.g. insulin and cortisone) and necessitate continuous  
23 use. This also makes continuous cost and can quite  
24 unbalance the economy of a family. If the bread  
25 winner is the one taking the drugs, there is no alter-  
26 native but that he must continue, but if it is some  
27 other member of the family and they are on a restric-  
28 ted income, the sick person may elect to suffer and  
29 risk death rather than spend so much of the weekly  
30



1 wage on drugs. Welfare workers often testify to  
2 this fact.

3  
4 Many people with a prescription in  
5 their hand go to a druggist and are astounded to  
6 find that the prescription costs ten dollars or  
7 more. Many will not have that amount of money with  
8 them and sometimes fail to have the prescription  
9 filled.

10 Wives of men on War Veterans' allo-  
11 wances are hurt by the high price of drugs. Their  
12 husbands get free medication but the wives must pay  
13 for theirs, and pensions are small.

14 Another aspect peculiar to buying  
15 drugs in contrast to other merchandise: the purchaser  
16 is usually ill herself or has someone at home who is  
17 sick. In either case, she is not able nor has the  
18 time to shop around to find out where she can get the  
19 prescription filled for the least money. In fact, we  
20 understand that it is the Pharmaceutical Association's  
21 aim to have a more or less standard price. This, we  
22 maintain, contravenes the Retail Price Maintenance Act.

23 Drug stores subscribe to a book called  
24 'Bulletin Services' which is in three sections giving  
25 the manufacturers' price for (1) Ethical Drugs; (2)  
26 Proprietary Medicines; (3) Sundries. Each drug store  
27 prepares its own price list from this. This is usually  
28 what the traffic will bear. We understand that price-  
29 cutting is frowned at and that prices are fairly  
30



1 uniform thus eliminating competition, and sustaining  
2 a retail price maintenance.

3  
4 GENERIC NAMES FOR DRUGS

5           There is much evidence that if drugs  
6 are ordered by their generic name rather than by  
7 Trade-Name there would be a considerable saving of  
8 money to the purchaser. This would necessitate the  
9 co-operation of the Physician and would put the onus  
10 on the Pharmacist to fill the prescription with the  
11 cheapest drug available. This might also increase  
12 the work of the Food and Drug Directorate.

13           We should like to pay tribute here to  
14 the Director and Staff of the Food and Drug Directorate  
15 who do such a fine job of inspecting food and drugs  
16 that the Canadian public can buy with the complete  
17 confidence that the food they eat and the drugs they  
18 take are safe. We could only wish that we could have  
19 the same confidence that we are getting the drugs at  
20 the lowest cost possible.

21  
22 PROMOTIONAL LITERATURE

23           We are concerned with the flood of  
24 promotional literature that every doctor receives.  
25 Most doctors are far too busy to read much of this  
26 literature and most of it goes into the waste paper  
27 basket. We believe that if the costs of these beauti-  
28 ful brochures on expensive paper, the almanacs, desk  
29 pads, et cetera, were eliminated it would reduce the  
30 cost of the drugs. In the USA, it is estimated that



1 a doctor receives an amount of four thousand pieces  
2 of literature per year. Directions for use that go  
3 into the package are necessary and are controlled  
4 by the Food and Drug Directorate. If this promo-  
5 tional literature could be reduced and facts rela-  
6 ting to new drugs be summarized by authoritative  
7 sources such as a combination of the Food and Drug  
8 Directorate and a medical committee from information  
9 supplied to them by the manufacturers it would save  
10 the doctors' time; would be authoritative; would  
11 eliminate this costly promotional expenditure and  
12 the saving could be passed on to the consumer in  
13 lower drug costs.  
14

15 DRUGS FROM FOREIGN LANDS

16 Lately Canada has been able to import  
17 drugs from European countries where no patents apply.  
18 These have not been too well-received by pharmaceu-  
19 tical companies, and one such company has been sued  
20 for patent rights. As all drugs must meet the stan-  
21 dards set up by the Food and Drug Directorate before  
22 being permitted to enter our market, and as these  
23 drugs are sold at lower prices, we believe that the  
24 field should be broadened to make competition keener  
25 and result in lower prices to the consumer.  
26

27 As this would necessitate more inspec-  
28 tions by the Food and Drug Directorate, we recommend  
29 that this Department be augmented to meet these  
30 increased demands.





PATENTED DRUGS

Vancouver and Victoria, because of their salubrious climate and mild winters, have a larger share of retired people than other places in Canada. Retired people, because of age, need drugs for their continued welfare. Because many of these retired people are on pension - or worse - have no pension, these drugs add to their financial worries, which in turn is deleterious to health. The drugs that many of them take, such as cortisone, are patented in the USA and are even higher in Canada because of Import Duties.

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PE/dpw

1                   The United States, we understand, has  
2  
3       no laws to prohibit the patents, but we believe  
4  
5       Canada has. The Compulsory Licensing laws could be  
6  
7       widened to meet this problem. These patents give a  
8  
9       monopoly on the manufacture and sale of these very  
10  
11       necessary drugs with a subsequent high price. We  
12  
13       feel that because of their necessity to the welfare  
14  
15       of a large percentage of the population some means  
16  
17       should be found to control the patents.

18                   Many of us have very clear memories  
19  
20       of the days before insulin the sulfonamides and the  
21  
22       antibiotics, and are grateful to the band of research  
23  
24       chemists and doctors who gave us these life-prolonging  
25  
26       drugs. Can we not see that they are now within the  
27  
28       financial reach of everyone?

29                   Respectfully submitted.

30                   THE CHAIRMAN: Mrs. McGhie, did you  
                  wish to add anything yourself to the brief?

                  MRS. MCGHIE: No, Mr. Chairman.

                  THE CHAIRMAN: I notice you have...

                  MRS. MCGHIE: I have just the evidence.

                  THE CHAIRMAN: The submission. Is  
                  this the sources from which the material was obtained?

                  MRS. MCGHIE: Yes.

                  THE CHAIRMAN: I see. I did want to  
                  ask you one question arising out of the last page,  
                  the matter of widening the compulsory licensing laws.  
                  Have you any suggestions as...



1 MRS. MCGHIE: No.

2 THE CHAIRMAN: What is amiss with  
3 the present law?

4 MRS. MCGHIE: I was afraid you might  
5 ask me that. It doesn't seem to work. It isn't  
6 used, as I understand.

7 THE CHAIRMAN: According to the infor-  
8 mation we have the right to get a compulsory licence  
9 is in the Act and according to the information we  
10 were given in Ottawa if the party who applies for a  
11 compulsory licence shows he is able to produce the  
12 drug satisfactorily he will get a compulsory licence,  
13 but apparently not too many people have applied.

14 MRS. MCGHIE: I understand that.

15 THE CHAIRMAN: That seems to be the  
16 situation, whether there is anything wrong with the  
17 law or not is a matter of some doubt.

18 MRS. MCGHIE: Yes.

19 THE CHAIRMAN: Mr. MacLeod, did you  
20 have any questions?

21 MR. MACLEOD: I was just wondering sir  
22 if perhaps the evidence should not be read into the  
23 record as well.

24 THE CHAIRMAN: This is the source as  
25 I understand from which the material in the brief was  
26 obtained.

27 MR. MACLEOD: It has certain specific  
28 examples that have come to the attention of the  
29  
30



1 Association, apparently.

2 THE CHAIRMAN: When I look at it it  
3 does consist of particular inferences.

4 MRS. MCGHIE: Yes, just examples.

5 THE CHAIRMAN: What appears to be  
6 hardship cases.

7 MRS. MCGHIE: Yes.

8 THE CHAIRMAN: Would you read that  
9 into the record, please, Mrs. McGhie, so it will be  
10 available to those studying the evidence.

11 MRS. MCGHIE: EVIDENCE - Re: USE OF  
12 GENERIC TERMS WHEN PRESCRIBING DRUGS: A member of  
13 the executive of the CAC was ordered "Equanil" by  
14 her physician. Fifty tablets cost \$6.75. As "Equa-  
15 nil" is the Trade Name, she asked her doctor whether  
16 or not it would be cheaper to prescribe it by the  
17 generic name. He said she could find out and gave  
18 the generic name of Meprobamate. These tablets were  
19 one hundred for \$2.75. There was also a similar  
20 preparation called Meprobamed, and the tablets were  
21 one hundred for \$3.65. She ordered the cheapest,  
22 and when they proved as effective the doctor  
23 continued to order these for her.

24 A common example of proprietary drugs  
25 being cheaper under the generic name is the case of  
26 aspirin. Five hundred ASA (acetylsalicylic acid)  
27 cost 95¢, while Bayer aspirin costs \$3.75 for that  
28 amount.  
29  
30



1 Dr. Schechter, Head of the Doctors'  
2 Pharmacy Committee of the Ottawa Civic Hospital,  
3 states that they use generic names wherever possible  
4 in the Hospital, and indicated that this was some-  
5 thing towards which more progress could be made.

6  
7 Re: CASE OF DRUGS BEING A HARDSHIP TO YOUNG COUPLES  
8 STARTING OUT IN LIFE

9 The wife of a young man in a low  
10 income bracket was ordered to take cortisone, the  
11 cost of which would be approximately \$7.00 a week,  
12 and she was told that she would always have to take  
13 the drug. This caused much worry and sadness in their  
14 married life which was unfortunately terminated by  
15 cancer.

16 Re: HIGH COST OF DRUGS IN PROPORTION TO INCOME OF  
17 ELDERLY COUPLE ON PENSION

18 One couple living on a pension of a  
19 retired banker pays approximately \$50.00 to \$60.00 a  
20 month for drugs. She has both diabetes and arthritis  
21 and he has a heart condition.

22 Re: HARDSHIP CAUSED TO A SINGLE WOMAN LIVING ON A  
23 RETIREMENT ALLOWANCE

24 Out of \$60.00 a month, she pays out  
25 \$13.20 for a six weeks' supply of drugs.

26 Re: STATISTICS THAT BRITISH COLUMBIA HAS THE LARGEST  
27 RETIRED POPULATION IN CANADA

28 "Retired or voluntarily idle, esti-  
29 mated number and percent of population 14 years or  
30



1 over, week ending June 17, 1961, British Columbia,  
2 90,000; 8.1 percent. While the category 'retired  
3 or voluntarily idle' includes persons of all ages,  
4 about 80 percent of them would be 65 years of age  
5 or over".

6  
7 Source: Canadian Labour Force Survey as quoted by the  
8 Dominion Bureau of Statistics.

9 THE CHAIRMAN: Thank you. I take it  
10 these individual cases you have listed here are all  
11 cases of which the details have been supplied to  
12 your Association?

13 MRS. MCGHIE: Yes, they are just  
14 representative. I have picked out three cases,  
15 three cases I knew personally.

16 THE CHAIRMAN: These are examples of  
17 the sort of thing you spoke of in the brief as  
18 having come to your attention?

19 MRS. MCGHIE: We have scores of them.  
20 I thought one example was enough.

21 MR. HUME: Mrs. McGhie, your organiza-  
22 tion - do I understand it is the British Columbia  
23 branch of the organization that submitted a brief to  
24 this Commission in Ottawa by Mrs. Plumptre?

25 MRS. MCGHIE: Yes.

26 MR. HUME: May I ask you if you would  
27 be good enough to turn to page 3 of your submission  
28 in which on the first line you refer to the Retail  
29 Price Maintenance Act. May I just assume you are  
30





1 referring to Section 34 of the Combines Act dealing  
2 with price maintenance?

3 MRS. MCGHIE: I know it only under this  
4 term.  
5

6 MR. HUME: I think possibly this could  
7 be stated for anybody reading the record: so far as I  
8 am aware there is no such act as the Retail Price  
9 Maintenance Act and retail price maintenance is prohi-  
10 bited and dealt with under Section 34 of the Combines  
11 Act.

12 THE CHAIRMAN: That is our information.

13 MR. HUME: One last question, you refer  
14 to the 11% sales tax and you refer later on to the  
15 import duties on the top of page 5. May I assume from  
16 your brief it is the opinion of your Association that  
17 both of these taxes should be removed in order to lower  
18 the cost of the product?

19 MRS. MCGHIE: We would like the 11% tax  
20 removed. I don't know what you can do about the  
21 import duty.  
22

23 MR. HUME: You could recommend to this  
24 Commission that they consider your recommendation that  
25 import duty on pharmaceutical products be removed for  
26 drugs or pharmaceuticals imported into Canada. Have  
27 you gone into that?

28 MRS. MCGHIE: I haven't given any  
29 thought to that. I thought that was something that  
30 would naturally have to be paid. The 11% - they both



1 would be the Government, wouldn't they?

2 MR. HUME: They are both taxes of one  
3 kind. If you take off sales tax would you agree it  
4 would follow it would also be reasonable that one  
5 might consider the removal of the import duties?  
6

7 MRS. MCGHIE: I don't think I know  
8 enough about that to say. I am sorry.

9 MR. HUME: Thank you. I would like to  
10 congratulate you on your brief. It is a very good  
11 brief.

12 THE CHAIRMAN: Thank you, Mrs. McGhie.  
13 We have two other briefs of which we have knowledge.  
14 There is the Federated Legislative Council of Elder  
15 Citizens' Association and the Pharmaceutical Associa-  
16 tion of British Columbia. It may be one of these may  
17 take a good deal of time. I notice the Pharmaceutical  
18 Association brief is somewhat longer than the other  
19 one. Is either of these associations anxious to be  
20 heard very quickly for any special reason?

21 MR. HINKSON: No, Mr. Chairman. We  
22 are in your hands. We are here.

23 THE CHAIRMAN: Perhaps we might hear  
24 the Legislative Council of Elder Citizens. They have  
25 a fairly short brief. Mr. Kelly, you are Vice-Presi-  
26 dent of the Association; is that correct?

27 MR. KELLY: That is correct.  
28  
29 Can. Pac. Pioneers (5) Can. Nat. Veterans (2)  
30 Senior Citizens Assn. Ret. Veterans R.C.M.P. Div. 7



1 Friendly Aid Society Happier Old Age B.C.E. Retired  
2 Employees B.C. Govt. Ret. Employees Vancr. Ret.  
3 City Firemen Chilliwack Sen. Cit's Social Centre  
4 B.C. Ret. Teachers' Assn. Victoria Fed. Leg. Council  
5 of Vet's Assn's Vancr. Isl. Pioneers of Can. Merchant  
6 Marine Guild  
7

8 FEDERATED LEGISLATIVE COUNCIL

9 Elder Citizens Associations

10 Vancouver, B.C.

11 Vice-President	President	Treasurer:
W.F. KELLY	W.R. JONES	A.C. HILL
900 Vista Cres.	4910 Willow St.	4280 Yukon St.
South Burnaby, B.C.	Vancouver 13, B.C.	Vancouver 15, B.C.
Phone LA 4-3139	Phone AM 1-7336	Phone TR 6-7794

14 Secretary:  
15 J.W. CHESTERMAN  
16 4935 Union St.  
17 Vancouver, B.C.  
18 Phone CY 8-5091

17 Gentlemen: We, a Delegation represen-  
18 ting the above thirteen organizations - the thirteen  
19 are listed on the letterhead on the first page -  
20 appear before you in a sincere spirit of co-operation,  
21 wishing to assist, if possible, in getting a true  
22 picture of the effects of excessive drug prices on the  
23 people of Canada and, more especially, on that group  
24 of Elderly Citizens who are what we term 'border-line'  
25 cases, people who are retired on static pension  
26 income and cannot qualify for 'social assistance'  
27 where drugs are provided.  
28

29 We represent a very large segment of  
30 the Elderly Citizens of British Columbia and our



1 numbers are constantly increasing. It is very evi-  
2 dent that we, of all age groups, can least afford  
3 excessive medication costs.  
4

5 Our Elder Citizens, of sixty years  
6 and over, have the greatest need for medication for  
7 the following reasons:

- 8 1. Because of chronic ailments.
- 9 2. Lower resistance at the out-set  
10 of disease.
- 11 3. Need for dietary supplements,  
12 such as Vitamins, in order to supple-  
13 ment body production of these elements.

14 As the age level increases this problem  
15 becomes more pressing and we feel that, to allow our  
16 Elder Citizens to finish out their lives with a modicum  
17 of health and comfort, some relief from the high  
18 cost of drugs should be made possible.

19 We are fully cognisant of the fact  
20 that the Manufacturer and the Pharmacist are entitled  
21 to a fair profit, but we feel that the subject of  
22 medication should be open to competition.

23 Since this is a Combines investigation,  
24 it is only proper that this aspect of medicine should  
25 be aired at this meeting.

26 The following factors contribute to  
27 the high prices of drugs and prevent the normal operation  
28 of economic competition.  
29

- 30 1. The misuse of drug patents to



1 protect monopolies.

2 (a) We understand that the greater  
3 percentage of drug patents are foreign  
4 held.

5 (b) The patents are possibly used as  
6 a means of preventing the manufacture  
7 of these commodities in Canada.

8 2. Medical Propaganda Techniques.

9 (a) Expensive wasteful advertising  
10 to indelibly stamp a 'trade' name in  
11 the Doctor's mind.

12 (b) Expensive samples and gadgetry.

13 (c) Introduction of too many dupli-  
14 cates and unnecessary products of  
15 little additional medical value.

16 3. Pharmaceutical Organization Execu-  
17 tives.

18 These spokesmen of the Pharmaceutical  
19 Association and Pharmacists invariably seem to favor  
20 the (brand) name on prescriptions. They make general  
21 statements about quality control and safety yet, they  
22 have never proved that the same drug under the chemi-  
23 cal name is not safe and efficient...

24 THE CHAIRMAN: When you speak of the  
25 Pharmaceutical Association, do you mean the Pharma-  
26 ceutical Manufacturers' Association which is rather  
27 different from the Pharmaceutical Association?

28 MR. KELLY: Yes, Pharmaceutical  
29  
30





1 Manufacturers' Association should be used.

2  
3 4. The 11% Sales Tax.

4 This represents a special hardship on  
5 the Group which requires the most medication and are  
6 least able to pay for it.

7 Medication and vital health necessi-  
8 ties should not be subject to taxes when they weigh  
9 most heavily on people who are already unfortunate.

10 The similarity in prices would  
11 definitely point to a lack of competition. Relative  
12 quality does not enter into the question. The  
13 question of inferior quality in drugs not bearing a  
14 'brand' name is a 'RED HERRING' produced by the  
15 major drug industry and is untenable.

16 These claims have never been substan-  
17 tiated by the Department of Health and Welfare.

18 In conclusion we would ask you to  
19 take into consideration the following suggestions:

20 1. Institute a medical formulary  
21 limiting the number of drugs in use to those of  
22 proven therapeutic ability and having adequate  
23 quality and safety controls. (This does not imply  
24 that new drugs should not be tested and investigated).

25 2. The formulary should be based on  
26 the approved generic name. A qualified formulary  
27 committee should prepare a list, duly approved, of  
28 'convenient' names available to all manufacturers in  
29 order to simplify prescription writing.  
30





3. All Doctors should abide by this  
formulary in writing prescriptions.

4. The Department of Health and  
Welfare should be empowered to licence and inspect  
pharmaceutical plants. Stringent quality control  
should be insisted upon.

5. Removal of sales tax at manufac-  
turers level on all prescription drugs and vitamins,  
also those drugs that are of therapeutic dosages and  
properties.

6. Compulsory licencing of all drugs  
three years after issue of patent.

If these suggestions are put into  
practice we feel that a free economic status will  
result in the drug industry and will lead to a consi-  
derable reduction in drug prices.

Respectfully submitted.

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'AG/dpw

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THE CHAIRMAN: Do you wish to add any comments, Mr. Kelly?

MR. KELLY: I have nothing further sir.

THE CHAIRMAN: I was going to just mention that the sixth point of your recommendations, compulsory licencing of all drugs three years after the issue of patent, I think the compulsory licence provision in the Act does not even require three years. I was wondering whether you mean compulsory licence or the abolition of the patent after three years?

MR. KELLY: Our idea was that the patent might run for three years, after which the formula should be made available to other manufacturers, under licence.

THE CHAIRMAN: That can be done now even without the three years, if they make application for it and satisfy the authorities that they are able to manufacture the drug satisfactorily.

MR. KELLY: Thank you.

THE CHAIRMAN: But I didn't know whether you meant that the patent would only have a three-year period and then become open to anybody. Apparently that is not what you meant.

MR. HUME: I have no questions, thank you sir.

MR. MACLEOD: No questions sir.



Kelly

1175

ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

1 THE CHAIRMAN: Thank you very much  
2 Mr. Kelly. Obviously the Federation has spent some  
3 time in studying this problem and in preparing the  
4 recommendations you made to us.  
5

6 MR. HUME: Mr. Kelly referred to the  
7 thirteen member organizations as being at the top  
8 of the letterhead. Unless there is some direction  
9 to the reporters, those names might be missed in  
10 transcribing the brief, and perhaps Mr. Kelly might  
11 like to have the names of his organization right at  
12 the head of his brief.

13 THE CHAIRMAN: The reporter will write  
14 into the record the names of the various organizations  
15 that are comprised in the Federated Legislative  
16 Council of Elder Citizens' Association.

17 We have one individual here, Mr. Lock-  
18 hart. Would your presentation take very long?

19 MR. LOCKHART: I don't believe it would.

20 THE CHAIRMAN: I was wondering whether  
21 you have a very lengthy presentation, because we  
22 don't want to keep the other organizations. If it  
23 is fairly short, come right forward and do it now.

24 MR. LOCKHART: I would like to state  
25 to this Commission that there is an organization in  
26 B.C. and possibly in Alberta that on two occasions  
27 has drugged sections of the population en masse,  
28 without their consent and against their will.

29 THE CHAIRMAN: Perhaps you might tell  
30



1 us a little bit about your own affairs. What is  
2 your business?

3 MR. LOCKHART: I am a forester in  
4 private business. I have been to the police. I  
5 believe that part of this problem exists because the  
6 people who are in control of drugs are being taken  
7 advantage of, and are not aware of what they do in  
8 some cases.

9 THE CHAIRMAN: The people who are in  
10 control are being taken advantage of?

11 MR. LOCKHART: Yes. This drugging was  
12 not carried out for no reason whatsoever. Obviously  
13 there was a gain to somebody over the handing out of  
14 these drugs. I went to the police in Burnaby and  
15 there I met, dressed in R.C.M.P. uniforms, a man I  
16 knew was not a policeman. I later met him in Revel-  
17 stoke dressed in the same suit, which resembled the  
18 R.C.M.P. I later visited him at his house, and he  
19 died last November.

20 THE CHAIRMAN: There was no connection  
21 between those facts?

22 MR. LOCKHART: No, I am merely stating  
23 I know the man, that is all. The other occasion I  
24 was down in Dr. Neilson's office and there met a man  
25 who claimed he was a retired doctor, and I met him in  
26 New Westminster dressed as a policeman. I met him in  
27 a restaurant in New Westminster, posing as a deaf  
28 mute, and I gave him 50 cents. He gave me a push with  
29  
30



1 a tow truck, and at the same time my car was inter-  
2 fered with. That is the operation. It was inter-  
3 fered with in several manners to make it difficult  
4 for me to use it.

5  
6 THE CHAIRMAN: I was just wondering  
7 what this has to do with drugs?

8 MR. LOCKHART: All right. I was hit  
9 by drugs in the telephone booth, when I was making  
10 a telephone booth, just before the directory was  
11 changed in the Spring of 1959.

12 THE CHAIRMAN: A telephone directory?

13 MR. LOCKHART: The telephone directory  
14 that was in the booth was the 1960 directory, and  
15 when I tried to make a call I couldn't, because I  
16 was looking up the number in the book, and the numbers  
17 which I called were in the new directory, so I didn't  
18 get a number. I received at this time a shot of  
19 drugs for my left foot.

20 THE CHAIRMAN: From what?

21 MR. LOCKHART: I would say --

22 THE CHAIRMAN: From a doctor?

23 MR. LOCKHART: No, I don't know who  
24 gave it to me because I didn't see what hit me.

25 THE CHAIRMAN: You were shot by some-  
26 thing?

27 MR. LOCKHART: I couldn't tell you  
28 that, I don't know.

29 THE CHAIRMAN: Something went into  
30



1 your foot?

2  
3 MR. LOCKHART: Obviously somebody  
4 took my shoe off and gave me a shot of drugs. This  
5 may sound a little bit strange. I am still faced  
6 with this problem, and I wouldn't be so much faced  
7 with it if the insurance company hadn't cancelled  
8 my coverage because of the interference of the  
9 control of my car by radio equipment. If this sounds  
10 a little bit strange, I see you are absolutely incre-  
11 dulous --

12 THE CHAIRMAN: We just wanted to get  
13 on to the subject we are looking into, which is drugs.  
14 Some of the things you are talking about might give  
15 you grounds for laying a complaint to the police, but  
16 I don't think they come within the scope of this  
17 inquiry.

18 MR. LOCKHART: All right. Drugs, I  
19 see. Well --

20 THE CHAIRMAN: What is this organiza-  
21 tion you spoke of?

22 MR. LOCKHART: I believe they hand out  
23 goof-balls.

24 THE CHAIRMAN: Do you know who they  
25 are?

26 MR. LOCKHART: No, I would say they  
27 operate primarily to control people in special condi-  
28 tions, because if you can control a person by having  
29 him come and go by taking a goof-ball, you pretty  
30





1 well decide what he does.

2  
3 THE CHAIRMAN: What we would be con-  
4 cerned with is who are the people, what is the orga-  
5 nization?

6 MR. LOCKHART: I will tell you one  
7 name. I don't know his name, I will tell you where  
8 you can find out his name. I first saw him on the  
9 street at Howe and Hornby, and I saw him at the  
10 Bluebird Cafe.

11 THE CHAIRMAN: Do you know his name?

12 MR. LOCKHART: No I don't.

13 THE CHAIRMAN: Do you know where he  
14 lives?

15 MR. LOCKHART: No.

16 THE CHAIRMAN: It is difficult for us  
17 to follow up that. We are not a detective agency.

18 MR. LOCKHART: Since this breeds on  
19 ignorance, that these things can exist, the mere fact  
20 that I stated here I believe will assist. Do you  
21 admit that there are such drugs and they can be  
22 handed out?

23 THE CHAIRMAN: I don't know what drugs  
24 you are talking about. You mentioned goof-balls. I  
25 have heard a lot about goof-balls lately. You are  
26 not giving us anything that directly bears on this  
27 inquiry, Mr. Lockhart. The situation you are speaking  
28 about might be quite serious, but it is not something  
29 we can do much about.  
30



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1 MR. LOCKHART: As you are a member of  
2 the Restrictive Trades Act. At the same time my car  
3 has been vandalized --

4 THE CHAIRMAN: You might have a complaint  
5 about your car being vandalized, but that has nothing  
6 to do with the manufacture and sale of drugs.

7 MR. LOCKHART: Is it possible to contact  
8 you as a member of the Restrictive Trade Commission?

9 THE CHAIRMAN: If you feel it involves  
10 the Act we work under, certainly.

11 MR. LOCKHART: What is the procedure?

12 THE CHAIRMAN: Just write a letter to  
13 the Restrictive Trade Practices Commission in Ottawa,  
14 outlining the facts.

15 MR. LOCKHART: Thank you.

16 THE CHAIRMAN: Mr. Hinkson?

17 MR. HINKSON: Mr. Denholm, the Registrar,  
18 is to present the brief. Perhaps it would assist you  
19 if Mr. Denholm, before commencing, gives you a short  
20 resume of his connection with the Pharmaceutical Associa-  
21 tion and his professional background.

22 THE CHAIRMAN: You may proceed in which-  
23 ever manner you wish.

24 MR. HINKSON: Before commencing with the  
25 brief, perhaps you will state briefly what association  
26 you have had with the Pharmaceutical Association in  
27 this Province?  
28

29 MR. DENHOLM: I have been Registrar of  
30



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1 the Pharmaceutical Association since October 1st 1957.  
2 Prior to that time I was engaged in the retail prac-  
3 tice of pharmacy from the time of my graduation as a  
4 pharmacist in 1951. During the time I was in retail  
5 practice I was on the council of the Pharmaceutical  
6 Association from 1954 to 1957, and on the council of  
7 the Canadian Association from 1954 to date.

8 MR. HINKSON: That is the Canadian  
9 Pharmaceutical Association?

10 MR. DENHOLM: Yes. During that period  
11 on the provincial council I had been President of the  
12 Association from 1956 to 1957.  
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SUBMISSION PRESENTED BY THE PHARMACEUTICAL  
ASSOCIATION OF THE PROVINCE OF BRITISH COLUMBIA.

MR. DENHOLM: Mr. Chairman and members of the Commission. The Pharmaceutical Association of the Province of British Columbia welcomes this opportunity to present to you a submission in connection with the inquiry now being conducted in relation to the manufacture, distribution and sale of drugs in Canada. This Association has been furnished with a copy of the material collected for submission to the Commission by the Director of Investigation and Research under the Combines Investigation Act.

It is understood by this Association that your inquiry is concerned chiefly with drugs sold on prescription.

This submission will deal with certain matters which have been commented on by the Director of Investigation and Research in the statement of material collected by him.

I might mention here, Mr. Chairman, we have hereafter referred to this collection of material as the Green Book, as has been the practice in past hearings.

By way of a brief introduction, we wish to direct your attention to the function of the Pharmaceutical Association of the Province of British Columbia.

MR. HINKSON: If I may interrupt there,



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1 Mr. Denholm.

2 Mr. Chairman, we have not appended  
3 the Pharmacy Act of the Province of British Columbia  
4 to this submission. However, reference will be made  
5 in this submission to the Pharmacy Act and to speci-  
6 fic sections.

7 Perhaps I could furnish at this time  
8 an office copy of the Pharmaceutical Act for the  
9 Commission.

10 THE CHAIRMAN: It would assist the  
11 Commission since you propose to refer to the Act.

12 MR. HINKSON: I have seven copies.

13 THE CHAIRMAN: We will treat this  
14 part of the Act as part of the brief.

15 MR. HINKSON: Fine, Mr. Chairman,  
16 thank you.

17 MR. DENHOLM: May I continue, sir?

18 THE CHAIRMAN: Yes, certainly.

19 MR. DENHOLM: This Association has  
20 been constituted a body politic and corporate under  
21 the provisions of the Provincial Pharmacy Act. We  
22 feel it is important to draw to your attention that  
23 throughout the Act it is clear that pharmacy is  
24 constituted as a profession within the Province of  
25 British Columbia. For example, a licensed pharmaceu-  
26 tical chemist is defined in the Pharmacy Act as:

27 "...a pharmaceutical chemist who is  
28 the holder of a licence in good  
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standing, entitling him to practice  
his profession in the Province".

The affairs of the Association are  
directed by a Council composed of elected members.  
The Council members are elected for a two-year term  
from geographical districts which cover the whole of  
the Province. The Council has power to make by-laws  
and regulations dealing with a variety of topics such  
as qualification and registration of students, appoint-  
ment of executive officers of the Association, disci-  
pline of members, affiliation with other professional  
organizations, in particular the Canadian Pharmaceu-  
tical Association and like matters. Such by-laws must  
be approved by the Lieutenant-Governor-in-Council  
before they come into force.

The two principal officers of the Asso-  
ciation are the Registrar and the Executive-Secretary,  
both fully qualified pharmacists employed full-time  
in administrative capacities.

It is provided in the Pharmacy Act  
that applicants for registration as licensed pharma-  
ceutical chemists must hold a degree of Bachelor of  
Science in Pharmacy from the University of British  
Columbia or equivalent qualifications, and must have  
served such period of practical training as the  
Council may establish under the by-laws and regula-  
tions of the Association. At the present time the  
period of practical training is fixed at one year.





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1 Provision is made in the Act for the  
2 licensing of pharmacies and it is expressly stipulated  
3 that each pharmacy must at all times, while it is  
4 open for business, be under the supervision of a  
5 licensed pharmaceutical chemist. Provision is also  
6 made in the Act that only licensed pharmaceutical  
7 chemists may practise the profession of a pharmaceu-  
8 tical chemist or keep open shop for retailing, dis-  
9 pensing or compounding poisons, drugs, or medicines.  
10 Under the Pharmacy Act prosecutions can be initiated  
11 against unqualified persons or companies which attempt  
12 to carry on the practice of pharmacy or the retailing  
13 of poisons, drugs and medicines.

14 The Pharmaceutical Association in  
15 this Province is, therefore, composed of licensed  
16 pharmaceutical chemists who carry on the practice of  
17 their profession mainly at the retail level. In  
18 addition, members of the Association are employed as  
19 pharmacists in hospitals, and as well, by companies  
20 engaged in the manufacture of drugs and as teachers  
21 on the Faculty of Pharmacy at the University of  
22 British Columbia.

24 The Act and the Schedules thereto  
25 contain restrictions on the sale of poisons and  
26 drugs. Such schedules are amended from time to time  
27 by resolution of the Council and in consultation  
28 with the Provincial Department of Health. One of  
29 the services provided by the Association to its  
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1 members is to publish a loose-leaf system of amend-  
2 ments which are kept up-to-date so that the member-  
3 ship at all times has the schedules in their current  
4 form.

5                   In these general provisions, the  
6 Pharmacy Act of British Columbia is similar to the  
7 Acts of many other professional bodies in Canada.  
8 Generally, it may be said that the Pharmaceutical  
9 Association of British Columbia is concerned with the  
10 education of prospective pharmacists, with qualifica-  
11 tions of applicants seeking to become registered  
12 members of the Association, with the practice of  
13 the profession by licensed pharmaceutical chemists,  
14 and with the sale of those poisons, drugs and medi-  
15 cines which under the provisions of the Act are  
16 limited to pharmacies.

17                   Within the Province of British Colum-  
18 bia, in addition to the restrictions on the sale of  
19 poisons, drugs and medicines imposed by the Pharmacy  
20 Act, certain restrictions are contained in the Food  
21 and Drugs Act of Canada and the Opium and Narcotic  
22 Drug Act. These three Acts, in our view, impose  
23 restrictions on the sale of drugs which may be the  
24 subject of misuse or social abuse and the responsi-  
25 bility for their distribution to the public is  
26 entrusted to pharmacists.

27                   Mr. Chairman, the first matter on  
28 which we wish to make comment is the reference by  
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1 the Director in the Green Book to the fact that in  
2 certain provinces the provincial pharmaceutical  
3 associations perform a dual function.

4                   The Director in this connection made  
5 reference to the fact that in some provinces there  
6 is a separate trade association and cited specifi-  
7 cally the Province of Ontario. He said that even  
8 where there is a province-wide trade organization,  
9 the governing body still exhibits a dual personality.  
10 These associations, the Director said, while on the  
11 one hand carrying out their statutory duties of  
12 licensing pharmacists, also concern themselves with  
13 what he referred to as "typical trade association  
14 activities" and, as well "the economic welfare of  
15 druggists as businessmen"; in particular, reference  
16 is made to the Provinces of Ontario and British  
17 Columbia.  
18

19                   Towards the end of the Green Book  
20 the Director once again commented on the propriety  
21 or otherwise of pharmacists' associations performing  
22 the dual role of regulating the practice of the pro-  
23 fession of pharmacy with all that this implies and  
24 at the same time acting as "trade associations"  
25 concerned with the economic welfare of their members  
26 as retail merchants.

27                   The British Columbia Pharmaceutical  
28 Association feels that it may assist the Commission  
29 if some comment is made on this aspect of the  
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1 Director's statement.

2 A consideration of the Pharmacy Act  
3 of British Columbia makes it clear that the practice  
4 of pharmacy in this province by a licensed pharma-  
5 ceutical chemist is the practice of a profession.  
6 At the same time, however, the Act makes it clear  
7 that in so practising his profession the pharmacist  
8 is engaged in a business.

9 With particular reference to the  
10 matter of prescriptions the pharmacist is perfor-  
11 ming a professional service in relation to the  
12 ingredients which are delivered to the customer in  
13 the form of a drug or medicine; thus everything that  
14 the pharmacist does in his professional capacity is  
15 in relation to the drug or medicine which is deli-  
16 vered to the patient.

17 The Pharmacy Act in a number of its  
18 provisions recognizes the close relationship between  
19 the practice of the profession of pharmacy and the  
20 carrying on of the business of a retailer of drugs  
21 and medicines.

22 Section 9(1)(m) of the Act provides  
23 that the Council may make by-laws dealing with the  
24 discipline of a member for, among other things,  
25 misconduct in the practice of his business or profes-  
26 sion.

27 Section 25 of the Act dealing with  
28 registration of medical practitioners under the  
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1 Pharmacy Act makes reference to carrying on business.

2                   Section 27(5) requiring a pharmacy to  
3 be under the management of a pharmaceutical chemist  
4 again has reference to the management of the business  
5 as distinct from the practice of the profession.

6                   Section 27(7) has reference to the  
7 sale of a business of a licensed pharmaceutical  
8 chemist or a corporation that operates a pharmacy.

9                   Section 29 deals with the operation  
10 of a pharmacy by a joint stock company and subsec-  
11 tions 3 and 4 again make reference to such a company  
12 which is actively engaged in carrying on business as  
13 a chemist and carrying on the business of a pharmacy.

14                   In addition, there are other sections  
15 in the Pharmacy Act which make reference to the prac-  
16 tice of a profession and the carrying on of a busi-  
17 ness.

18                   It would appear that the Director  
19 regarded the function of the governing body in phar-  
20 macy in each of the provinces to be limited to the  
21 control of the practice of the profession.

22                   In many of the professions services  
23 only are supplied. This is so in the practice of  
24 law, in accountancy, in teaching, in architecture  
25 and mainly so in medicine and engineering. In  
26 dentristy and to a greater extent in optometry, goods  
27 as well as services may be supplied.

28                   Pharmacy is unique however, by reason  
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1 of the fact that in the case of prescription drugs  
2 the services rendered are always in relation to the  
3 drug or drugs which the pharmacist supplies to the  
4 patient.

5                   Thus, in any discussion of prescrip-  
6 tion drugs it is impossible to talk about the profes-  
7 sion of pharmacy without at the same time discussing  
8 the buying and selling of drugs. The two subjects  
9 are inextricably bound up, and this fact, we believe,  
10 has been recognized in the Pharmacy Act of the Pro-  
11 vince of British Columbia. It is because of these  
12 circumstances that you find the governing bodies in  
13 Pharmacy concerning themselves with the supply of  
14 drugs from the manufacturer to the retailer, the  
15 supply of drugs by the pharmacist to the patient,  
16 the offering of drugs from the manufacturer to physi-  
17 cians in the form of samples, the distribution of  
18 samples by physicians to their patients and, as well,  
19 the quality of the products supplied by the pharmacist  
20 to the patient, whether on the instructions of the  
21 physician or by his own authority.

23                   From a practical point of view it is  
24 difficult to determine just where the line should be  
25 drawn between those matters which are the proper  
26 concern of this Association in regulating the prac-  
27 tice of pharmacy and the conduct of the business of  
28 pharmacists from those matters which deal primarily  
29 with the economic welfare of pharmacists as businessmen,  
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1 if indeed such a distinction is to be made.

2                   This Association has always regarded  
3 its proper and main function to be the maintenance  
4 of the highest standards of the profession by its  
5 members, coincidental with the welfare of the public  
6 in the compounding, dispensing and selling of drugs,  
7 medicines and poisons.

8                   The Association, through the Council  
9 and through its permanent officials, has at no time  
10 permitted or encouraged individual members to pre-  
11 vail upon it to act in the interests of business  
12 expediency, where such action would be outside the  
13 proper scope of the functions of the Association or  
14 contrary to the protection of the public interest  
15 which has been entrusted to it.  
16

17                  Mr. Chairman, the second matter upon  
18 which we wish to comment is the reference by the  
19 Director in the Green Book to recommended price  
20 schedules published by the provincial associations  
21 and others in various parts of Canada. The Director  
22 found, as the fact is, that in British Columbia no  
23 suggested prescription price schedule is published  
24 by the Pharmaceutical Association.

25                  Committees of the Association have  
26 from time to time discussed professional fees and  
27 prescription prices, both from the point of view of  
28 the members of the Association and from the point of  
29 view of prices being charged to the public.  
30



1 At no time has any action, official  
2 or otherwise, been taken by the Committees or by the  
3 Council of the Association with respect to the  
4 fixing of a professional fee in relation to drugs  
5 sold on prescription nor to the regulating of pres-  
6 cription prices. Rather, the attention of these  
7 Committees has been directed to problems arising  
8 from changing circumstances at the manufacturing and  
9 retail levels in relation to prescription drugs and  
10 to efforts to resolve such problems.

11 At all times these discussions have  
12 been directed to seeking recommendations and solu-  
13 tions, such as would be permitted by law.

14 In this connection the Director made  
15 reference to the acceptance by retail pharmacists of  
16 the list price commonly published by manufacturers,  
17 and referred to the fact that such list price in the  
18 majority of cases is the retail price ultimately  
19 charged to the patient. The Director concluded that  
20 retail pharmacists adopted the manufacturers' list  
21 price because that was the basis for all trade prices  
22 and was regarded as the only proper selling price.  
23 He further concluded that pressure exerted by pharma-  
24 cists' associations on members to maintain prices  
25 also tended to assist in the retail pharmacist  
26 following the list price. This latter conclusion  
27 was based on his belief that pressure was exerted  
28 through the schedules of suggested prices prepared by  
29  
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1 the Provincial Pharmaceutical Associations and by  
2 the general view that most pharmacists appear to  
3 frown on price competition in the pricing of pres-  
4 criptions as verging on unethical professional  
5 conduct.

6                   These conclusions by the Director do  
7 not have application to the Province of British  
8 Columbia. We have already confirmed the Director's  
9 finding that this Association has not at any time  
10 published a schedule of suggested prescription prices.

11                   Further, the Association has always  
12 held the view that it is no part of its function to  
13 frown on price competition in the pricing of pres-  
14 criptions or to attempt disciplinary action of  
15 members who engage in such competition.

16                   Dealing specifically with the sugges-  
17 tion of the Director that pressure has been exerted  
18 by the Association on its members to accept the list  
19 price published by manufacturers, again, the Associa-  
20 tion has not considered such action to be a proper  
21 part of its functions and neither directly or indirectly  
22 has such pressure been exerted.

23                   In recent years there has been a signi-  
24 ficant change in the character of prescriptions.  
25 Twenty years ago there were relatively few drugs pre-  
26 pared in final dosage form by the manufacturer. In  
27 the main the pharmacist, using a few basic ingredients,  
28 compounded and dispensed the drugs prescribed by the  
29  
30



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1 physician. The basic cost of the ingredients was of  
2 less significance, while the cost of professional  
3 services was a greater proportion of the price to  
4 the patient. Generally, pharmacists took little  
5 cognizance of the cost of the ingredients in arriving  
6 at the price of the prescribed article to the patient.  
7 The method was largely empirical. Now today the  
8 pharmacist dispenses a greater number of prescrip-  
9 tion items compounded at the manufacturers' level  
10 and, in addition, compounds prescriptions containing  
11 basic ingredients which are relatively expensive. As  
12 a result the cost of the ingredients in relation to  
13 the final prescription price has become a greater  
14 factor.

15  
16 In the ordinary course of a day's  
17 business the pharmacist may dispense and compound a  
18 considerable number of prescriptions. To stop each  
19 time and calculate the cost of the ingredients, the  
20 cost of overhead, and the cost of the professional  
21 service is not practical and, therefore, the pharma-  
22 cist has tended to rely on the manufacturers' list  
23 price. During this period of twenty years the manu-  
24 facturer in publishing his catalogue has resorted to  
25 the practice of showing a list price for the drug.



As between the manufacturer and the pharmacist the list price is the same to all pharmacists. From such list price the manufacturer allows certain discounts. Among pharmacists at the retail level the basic price upon which all business is done is the manufacturers' list price. While the pharmacist may not know exactly the cost of overhead nor keep track precisely of the amount of time involved in compounding or dispensing, he does know the list price and the cost to himself and we believe that largely as a matter of convenience pharmacists have found the list price to be a satisfactory guide in arriving at the final cost of the prescription to the patient.

The suggestion by the Director that provincial associations have exerted pressure on their members to adhere to such a price is certainly not the case within the Province of British Columbia.

Mr. Chairman, the third matter upon which this Association wishes to make comment is the reference by the Director in the Green Book to the matter of a professional fee. The Director comments that if a drug is sold on prescription, the pharmacist usually adds a professional fee to the normal retail price.

In the Green Book it is stated that according to officials of the Food and Drug Directorate it was estimated in 1957 that counting





1 different brands and different dosage forms there  
2 were about 26,000 different drugs sold in Canada.  
3 It was also estimated at the same time that presen-  
4 tations on about 150 new drugs were submitted to  
5 the Directorate each year.

6                   The Director also made comment in the  
7 Green Book about the changed role of the pharmacist  
8 in the light of innovations by manufacturers within  
9 the drug industry. The Director estimated that up  
10 to 85% and possibly more of the prescriptions presen-  
11 ted are filled with drugs compounded by the manufac-  
12 turer.

13                   The Director in the Green Book  
14 touched upon the responsibility resting on the phar-  
15 macist in the dispensing and compounding of pres-  
16 cription drugs and the distinction between the  
17 supply of drugs on prescription from an ordinary  
18 commercial transaction.

19                   In our view there are other equally  
20 valid considerations which enter into the propriety  
21 of charging a professional fee. The changes that  
22 have occurred as a result of research and develop-  
23 ment together with introduction of new drugs in  
24 recent years have required a much more specialized  
25 training of the prospective pharmacist.

26                   In British Columbia, the University  
27 course leading to a degree of Bachelor of Science in  
28 Pharmacy is now a four-year course. The entrance  
29  
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1 requirements are full senior matriculation. The  
2 next four years are specifically designed to prepare  
3 the pharmacist to practise his profession.

4           The pharmacist's concern with sub-  
5 stances of many kinds employed in modern health  
6 services makes it necessary that he have extensive  
7 knowledge of chemistry and some understanding of  
8 physics and mathematics. In order to handle drugs  
9 properly, he must be fully conversant with their  
10 chemical and physical properties and reactions.  
11 Furthermore, it is the ultimate purpose of the drugs  
12 the pharmacist handles to modify, accelerate, decelerate,  
13 rate, or inhibit the functioning of a cell, a tissue,  
14 an organ, or an organism. In order that he may  
15 intelligently and helpfully supply the materials to  
16 do this it is essential that he must know something  
17 about the physiology of cells, tissues, organs and  
18 organisms, and how they are modified by malnutrition  
19 or disease, and how they respond to drugs. Because  
20 it is the responsibility of the pharmacist to  
21 dispense dosage forms of medication which most effectively  
22 present the medicinal agent, it becomes his  
23 responsibility to know the pathways by which drugs  
24 may be administered and the dosage form of each drug  
25 which is most suitable for each pathway. Such knowledge  
26 calls for a substantial study of the several  
27 biological sciences.

28  
29           The core of professional subjects to  
30



1 which the pharmacy student must devote a major part  
2 of his study centres around pharmacognosy, pharma-  
3 ceutics, pharmaceutical chemistry and pharmacology.  
4 In pharmacognosy, which deals with the 'materia  
5 medica' of modern pharmacy -- the animal, vegetable  
6 and chemical drugs, the fundamental principles  
7 learned in botany, bacteriology, chemistry and bio-  
8 chemistry are applied. The student must acquire  
9 certain pharmaceutical techniques which he must  
10 perform with skill and dispatch. Underlying these  
11 techniques is a vast body of factual information  
12 which must be well learned and instantly available  
13 to him. Recent research and the application of more  
14 advanced principles of physics and chemistry are  
15 becoming of increasing significance in instruction  
16 in this area.

18                   Most significant, too, is the greater  
19 emphasis being placed on the study of pharmacology.  
20 As modern medication has become more and more complex  
21 the opportunity and the need for pharmacies to become  
22 "clearing houses" of information on medicines is  
23 becoming increasingly recognized. Consequently,  
24 today pharmacists are being trained who are capable  
25 of assuming the role of consultant on drugs to the  
26 physician, to collaborate with him in evaluating  
27 claims and judging efficacy and safety of new and  
28 competing medicines. The pharmacist today must be  
29 an expert on drugs, a source of up-to-date information  
30



1 that can be used by the physician much more expedi-  
2 tiously than the overwhelming volume of modern  
3 technical literature. To accomplish such a function  
4 requires an extensive knowledge of pharmacology,  
5 and, in particular, of the structure-activity  
6 relationship of drugs.

7               In the area of pharmacy administra-  
8 tion a group of subjects is taught which might best  
9 be described as professional orientation. Such  
10 matters as public health, professional communication,  
11 ethical considerations, the history of pharmacy and  
12 laws and regulations pertaining to pharmacy are  
13 within this scope.

14               The Commission will appreciate the  
15 function the pharmacist performs in the field of  
16 prescription drugs. The physician prescribes for  
17 the patient and it is up to the pharmacist to fill  
18 that prescription. He must have an inventory of  
19 drugs of the proper dosage and in the proper state  
20 of activity to meet the physician's requirements.

21               The pharmacist must also be able to  
22 discuss with the physician at his request the rela-  
23 tive merits of comparable products, not only the  
24 efficacy of different brands; but the merits of  
25 related products.

26               It is difficult for the physician  
27 to keep up to date on modern medications because  
28 of the growth in numbers of new products and as a  
29  
30



1 result there is an increasing trend for physicians  
2 to rely on pharmacists for information on new pro-  
3 ducts. We believe that in the future the physician  
4 will come to require to a growing extent this type  
5 of service from the pharmacist.

6 Further, the physician often relies  
7 on the pharmacist to explain to the patient the  
8 manner of using the prescribed drugs, merely noting  
9 on his prescription "as directed". If any ambiguity  
10 is apparent in the prescribed manner of use, the  
11 pharmacist is obliged to consult with the physician.

12 In addition to these professional  
13 services performed by the pharmacist to the physician  
14 on behalf of the patient, the pharmacist performs  
15 additional services directly to the patient. He  
16 keeps a prescription file for future reference. Where  
17 a prescription is written for restricted drugs, the  
18 pharmacist must get in touch with the physician  
19 before he is permitted to repeat the prescription at  
20 the request of the patient.

21 In the field of dermatological and  
22 ophthalmological prescriptions, few are compounded  
23 by the manufacturer and in this field the pharmacist  
24 still compounds many prescriptions.

25 In the case of narcotics, restricted  
26 drugs and poisons records of various kinds are  
27 required to be kept by the pharmacist with respect  
28 to each such sale.  
29  
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1 In the case of all prescription

2 drugs the pharmacist is responsible for the labelling  
3 of the containers and must interpret the prescription  
4 and explain to the patient the dosages prescribed.  
5 Today, in the case of many drugs it is necessary to  
6 explain to the patient the matter of storage instruc-  
7 tions, as this may have an important bearing on the  
8 state of activity of the drug.

9 Finally, it will be apparent that in  
10 dispensing, with more than 23,000 different drugs  
11 and dosage forms being sold in Canada the matter of  
12 nomenclature may be very confusing and takes consi-  
13 derable specialized training on the part of the  
14 pharmacist, and it is a very important professional  
15 service performed by him each time a prescription  
16 is dispensed.  
17

18 It is upon a consideration of these  
19 factors as well as those touched upon by the Direc-  
20 tor in the Green Book that the pharmacist considers  
21 he is entitled to charge a professional fee in  
22 connection with dispensing and compounding of pres-  
23 cription drugs for the patient.

24 Mr. Chairman, the fourth matter upon  
25 which this Association wishes to comment is the  
26 duplication of drugs on the market in Canada today  
27 under various names, brand or generic. This matter  
28 was referred to in several contexts by the Director  
29 in the Green Book and has already been discussed  
30





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1 in some earlier presentations to the Commission. It  
2 will undoubtedly be dealt with at length in other  
3 submissions to you. We wish to restrict our discus-  
4 sion of the subject at this time to its effect upon  
5 the retail practitioner of pharmacy in British  
6 Columbia and the role the Association has played in  
7 advising and guiding its members in meeting the  
8 problems involved.

9  
10 The pharmacist has no control over  
11 the physician's choice of the drug, since the selec-  
12 tion of the drug is vested exclusively in the physi-  
13 cian.

14 When a prescribed drug is specifically  
15 identified by company of manufacture whether through  
16 a "brand name" or the inclusion of a company name on  
17 the prescription, the pharmacist has no alternative  
18 but to supply that specific make of the drug. In  
19 such cases the responsibility of selecting the manu-  
20 facturer as well as the drug itself has been assumed  
21 by the physician.

22 When, however, the prescribed drug  
23 is identified only by its "generic" name the respon-  
24 sibility of selecting the company of manufacture  
25 rests with the pharmacist. It is with this respon-  
26 sibility that the Association has chiefly concerned  
27 itself.

28  
29 In our view the pharmacist is legally  
30 and morally responsible for the identity, standard





1 and quality of the drugs he dispenses. Further, it  
2 is our view that this Association is responsible to  
3 ensure, insofar as is possible, that drugs dispensed  
4 by the pharmacists to the public are of known stan-  
5 dard and quality.

6           The Commission has already been  
7 informed by Dr. C.A. Morrell, the Director of the  
8 Food and Drug Directorate of the Department of  
9 National Health and Welfare that the Department does  
10 not check every batch of every drug manufactured in  
11 or imported into Canada. He has further stated that  
12 not all companies whose drugs are distributed in  
13 Canada undertake quality control procedures.

14           Our concern is not based on a consi-  
15 deration of price but rather on the question of  
16 whether or not quality control procedures have been  
17 followed during the course of manufacture. We hold  
18 no views as to whether small manufacturers are prefe-  
19 rable to large or as to whether drugs manufactured  
20 in Canada are preferable to those imported from  
21 abroad. Our interest rather has centred on what  
22 control procedures have been followed by the manufac-  
23 turer during the course of production.

24           For this reason, on occasion we have  
25 drawn to the attention of our membership the fact  
26 that the Food and Drugs Act does not require quality  
27 control procedures in the manufacture of all drugs  
28 and pharmaceuticals in Canada, nor is any such  
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1204

1 requirement imposed in respect of all drugs imported  
2 from abroad. Our concern has been, in the interests  
3 of public health, to draw to our members' attention  
4 the fact that it is their responsibility to dispense  
5 drugs of known quality.

6 We understand that Dr. Morrell has  
7 also informed the Commission that amendments to the  
8 regulations of the Food and Drugs Act requiring  
9 quality control in the manufacture of all drugs and  
10 pharmaceuticals are to be implemented. This Associa-  
11 tion whole-heartedly supports such amendments as  
12 being in the interests of public health in Canada.

13 Mr. Chairman, members of the Commission,  
14 the comments in this submission have been made to  
15 assist the Commission in arriving at the facts concer-  
16 ning the practice of pharmacy in the Province of  
17 British Columbia.

18 We have not attempted to discuss all  
19 the matters relating to the practice of retail phar-  
20 macy in British Columbia. If we can furnish further  
21 information for the assistance of the Commission, we  
22 are quite prepared to do so.

23 All of which is respectfully submitted.  
24  
25  
26  
27  
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1 THE CHAIRMAN: Thank you very much  
2 Mr. Denholm. Do you wish to add any comments?

3 MR. DENHOLM: I have no comments, but  
4 we understand that you have been advised that the  
5 Canadian Pharmaceutical Association will be making a  
6 submission when the Commission is sitting in Toronto,  
7 and they will, to some extent, be dealing with statis-  
8 tical matters, and we have not therefore concerned  
9 ourselves with those statistical matters in this  
10 brief, because we will be associated with the  
11 Canadian Association in their submission.

12 MR. HUME: Mr. Denholm, in the final  
13 section of your brief, concluding as it does at the  
14 bottom of page 16 and the top of page 17, you have  
15 developed the reasons for the concern of your Asso-  
16 ciation in dispensing products of which you have  
17 confidence in the quality control. You don't,  
18 however, conclude by indicating whether or not you  
19 take any active part as an Association in advising  
20 your members as to the method by which they ensure  
21 that quality control. Would you like to make a  
22 comment as to whether you take any part in investi-  
23 gating the quality control procedures of manufac-  
24 turers?

25  
26 MR. DENHOLM: I stated it in the  
27 second paragraph on page 16. We have on occasion  
28 drawn to the attention of our members the fact that  
29 the control procedures are not required in the Food  
30



1 and Drugs Act and so on. We have circularized our  
2 members to that effect, and indicated to them that  
3 they must exercise discretion in the choice of phar-  
4 maceuticals when the choice is left to them, and  
5 pointing out that quality must be their first consi-  
6 deration.

7  
8 MR. HUME: You don't have a list of  
9 approved manufacturers?

10 MR. DENHOLM: No.

11 MR. HUME: I only just saw this brief  
12 this morning, and I am noting a point as I went  
13 through. You are Registrar of the Association. I  
14 am sorry, I missed in your qualifications, are you,  
15 or have you been, a practising pharmacist in this  
16 Province?

17 MR. DENHOLM: A retail practising  
18 pharmacist from 1951 to 1957.

19 MR. HUME: Can you indicate whether  
20 in your view, whether by some change in legislation  
21 from coast to coast in Canada, you took away from  
22 the doctor his right to prescribe the drug he wants,  
23 whether a doctor is required to prescribe a drug  
24 under its generic name. Would the pharmacists in  
25 British Columbia dispense more generic name drugs?

26 MR. DENHOLM: I am not too sure that  
27 I understand the question.

28 MR. HUME: It is my fault. It has  
29 been suggested from more than one source that there  
30



1 ought to be some requirement where doctors are  
2 required to write a prescription using the generic  
3 name only. My question is, if that came about, is  
4 it your view that the pharmacists in this Province  
5 would continue to use about the same proportion of  
6 brand name as opposed to generic name drugs as they  
7 do now?

8                   MR. DENHOLM: I don't know that I  
9 would be able to say whether there would be any  
10 change. I would certainly say there would be the  
11 same position would pertain to the pharmacist as it  
12 does now. He would be responsible, but if this was  
13 a law, as you say, he would then be responsible for  
14 the choice in all cases, rather than in the few  
15 restricted cases as he is now. I would hesitate to  
16 say whether this would make any difference to the  
17 dispensing habits of the pharmacist.

18                   MR. HUME: If today the doctor pres-  
19 cribes a particular product, identified with the  
20 manufacturer's name, and there is something wrong  
21 with that, it is a bad batch let us say, and causes  
22 some bad side effects. The doctor having prescribed  
23 it, the pharmacist is concerned I am sure, but from  
24 the standpoint of his responsibility he has done  
25 exactly what he has been told.

26                   MR. DENHOLM: The responsibility is  
27 assumed by the physician in this case.

28                   MR. HUME: Under your Act, if a  
29  
30





1 pharmacist receives a prescription under generic name  
2 and makes the selection and there is something wrong  
3 with the batch, is the pharmacist responsible?

4 MR. DENHOLM: The pharmacist is respon-  
5 sible for the prescription he dispenses.

6 THE CHAIRMAN: Your views, and possibly  
7 the views of the Association, following up what Mr.  
8 Hume has been dealing with, if doctors were required  
9 to prescribe by generic name, and if the pharmacist  
10 is satisfied in his own mind that a certain drug  
11 which is prescribed is manufactured with proper qua-  
12 lity control measures, would he have any hesitation  
13 in supplying that drug, rather than one sold under a  
14 trade name?

15 MR. DENHOLM: None whatsoever. The  
16 prime point is your reference to the quality of the  
17 drug. This must be the pharmacist's first consid-  
18 eration. Once this consideration has been satisfied,  
19 then there is no further requirement sir.

20 THE CHAIRMAN: There is no further  
21 requirement, I am just wondering what the practice  
22 of the pharmacists in British Columbia today is,  
23 if you can speak about that practice. Do they depend  
24 almost entirely on the larger, well-established,  
25 reputable firms making a variety of products, or do  
26 they seek to ascertain whether smaller firms, not  
27 so well-known, do carry on proper and adequate con-  
28 trol procedures, so that they can safely make use  
29  
30





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1 of their products. Are you able to speak on that  
2 subject?

3 MR. DENHOLM: Only to say, sir, that  
4 the individual pharmacist does not have the facilities  
5 to determine whether company 'X', you mentioned one  
6 of the smaller, newer companies, has these require-  
7 ments of quality control or not. Where it is demon-  
8 strated to him to his professional satisfaction, and  
9 insofar as he can be assured, he would have no hesita-  
10 tion in using these drugs.

11 THE CHAIRMAN: What I am getting at is  
12 this. There are a number of large manufacturing  
13 concerns, most of them have been established quite a  
14 long time, and I think we can agree that they have  
15 acquired a good reputation. Other smaller drug  
16 manufacturers may confine their activities to a rela-  
17 tively few drugs. They would not require anything  
18 like the same complex establishment. Is it feasible  
19 for the drugs, or for your Association to ascertain  
20 whether a small manufacturer of that kind has ade-  
21 quate control procedures for the drugs that that  
22 manufacturer actually produces? Is that still  
23 beyond the scope of what might be expected from the  
24 Association?

25 MR. DENHOLM: Well, we believe that  
26 we should rely to a larger extent on the Food and  
27 Drug Directorate for this substantiation of proce-  
28 dures.  
29  
30



1 THE CHAIRMAN: You mean the Food and  
2 Drug Directorate, that in your view must be looked  
3 to for the purposes of establishing whether proper  
4 procedures are followed?

5 MR. DENHOLM: Indeed.

6 THE CHAIRMAN: And it is really out-  
7 side the scope of what the Association might be  
8 expected to do?

9 MR. DENHOLM: From an investigative  
10 view I would say so. The Food and Drug Directorate  
11 has the facilities for this, and while Dr. Morrell  
12 has indicated to you he does not have enough staff,  
13 he certainly is doing the best he can within the  
14 limitations of the staff he has, and we rely on them  
15 fairly heavily.

16 THE CHAIRMAN: The statement on page 16,  
17 I am not sure of the full meaning. You referred to it  
18 in replying to Mr. Hume, about the middle of the page:  
19 "...the Food and Drugs Act does not require quality  
20 control procedures in the manufacture of all drugs and  
21 pharmaceuticals in Canada..." Do you mean by that  
22 that no quality control procedures are required with  
23 respect to any drugs and pharmaceuticals, or not all  
24 of them?

25 MR. DENHOLM: Not all of them.

26 THE CHAIRMAN: Then with regard to your  
27 own Association, must all practising pharmacists be  
28 members of the Association? They must have a licence,  
29  
30



1 but must they be members of the Association?

2 MR. DENHOLM: Yes sir. Membership  
3 in the Association is part of the licensing require-  
4 ment.

5 THE CHAIRMAN: With regard to corpora-  
6 tions operating pharmacies, glancing rapidly through  
7 the Act and what was in the brief, the question  
8 occurs to me whether the provisions requiring owner-  
9 ship and majority of shareholders and so on mean  
10 that large department stores like Woodwards or the  
11 T. Eaton Company or the Hudson's Bay Company would  
12 not be in the position where they could operate a  
13 pharmacy in British Columbia.

14 MR. DENHOLM: The present regulation,  
15 covered in Section 27 of the Act, requires that a  
16 corporation operating a pharmacy must have a majority  
17 of its directors licensed pharmaceutical chemists,  
18 and a majority of the common stock held by licensed  
19 pharmaceutical chemists. This is the state today.  
20 This came into force by an amendment to the Act in  
21 1948. As is usually the case with new legislation,  
22 a saving provision is included for those companies  
23 which were incorporated prior to 1948 with respect  
24 to that portion of the Section which requires the  
25 majority of common stock to be held by pharmacists.  
26 The other requirement, that the majority of directors  
27 must be pharmacists, still holds. These corporations,  
28 in the case of the department stores you have  
29  
30



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Denholm

1212

1 mentioned, they all fall into this category, and have  
2 established separate corporations, and the majority  
3 of the directors of these corporations are pharmacists.

4 THE CHAIRMAN: Do you mean they set up  
5 new corporations for the purposes of handling their  
6 pharmaceutical work?

7 MR. DENHOLM: Yes sir.

8 THE CHAIRMAN: So it is not Woodward's  
9 corporation, but a subsidiary?

10 MR. DENHOLM: Woodward's Stores Drugs  
11 Limited is the official name.

12 THE CHAIRMAN: The provisions are some-  
13 what similar to those in Ontario?

14 MR. DENHOLM: I believe so.

15 THE CHAIRMAN: I was wondering how it  
16 was operating here. The large department stores have  
17 pretty well brought themselves within the scope of  
18 the present legislation?

19 MR. DENHOLM: They have.

20 THE CHAIRMAN: But smaller companies  
21 may not be in that position if they haven't taken  
22 steps to set up a corporation in which the majority  
23 of shares were held by pharmacists?

24 MR. DENHOLM: This must now be done  
25 sir.

26 MR. MACLEOD: Mr. Denholm, the drugs  
27 which may be sold by licensed pharmacists on the one  
28 hand, and by other outlets on the other, are set out  
29  
30



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1 in schedules to the Act, is that correct?

2 MR. DENHOLM: Yes sir.

3 MR. MACLEOD: Is Schedule B, Part 1,

4 may the drugs listed in that schedule be sold by any  
5 outlet?

6 MR. DENHOLM: Yes, that is true.

7 MR. MACLEOD: Are Schedule B, Part 2,  
8 those are drugs which may be sold by any outlet when  
9 that outlet is five miles away from a licensed pharma-  
10 cist, is that correct?

11 MR. DENHOLM: That is correct.

12

13

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1 MR. MACLEOD: And subject to Schedule  
2 B, Parts 1 and 2, all other drugs must be sold by a  
3 licensed pharmacist?

4 MR. DENHOLM: That is correct, sir,  
5 under varying circumstances, depending on whether  
6 they happen to be under Part 1, 2 or 3 of Schedule A.

7 MR. MACLEOD: Schedule A, Part 1:  
8 "May only be sold on prescription".

9 MR. DENHOLM: Right.

10 MR. MACLEOD: Part 2: "Drugs required  
11 to be entered into the Poison Registry may only be  
12 sold to a person known to the pharmacist". Is that  
13 correct?  
14

15 MR. DENHOLM: That is correct, sir.

16 MR. MACLEOD: That is the effect of  
17 that?

18 MR. DENHOLM: Yes.

19 MR. MACLEOD: Part 3, are drugs which  
20 may be sold freely by a licensed chemist, by a  
21 licensed pharmaceutical chemist. That is correct?

22 MR. DENHOLM: Yes, with the exception,  
23 sir, that those marked 'X' must be labelled "Poison".

24 MR. MACLEOD: Those marked 'X' must  
25 be labelled "Poison" - yes.

26 THE CHAIRMAN: It looks like a pretty  
27 substantial part of the list.

28 MR. DENHOLM: Yes.

29 MR. MACLEOD: Now, I understand there  
30





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1215

1 is something in British Columbia known as the B.C.  
2 Formulary or something like that. Would you explain  
3 to the Commission what that is and the circumstances  
4 under which it is used?

5 MR. DENHOLM: Yes. The B.C. Formulary  
6 was drawn up originally - I am afraid I can't give you  
7 the exact date without referring to our files - quite  
8 some time ago as a guide for prescribing and dispen-  
9 sing as is generally the function of a formulary.  
10 It came to be used as the basis of drugs which would  
11 be supplied to welfare recipients in the Province  
12 and paid for by the Provincial Government.

13  
14 It thus became the basic drug list  
15 of available drugs for those persons who are wards  
16 of the Government for one reason or another.

17 At the present time the use of the  
18 B.C. Formulary is nil. It has been superseded, sir.

19 MR. MACLEOD: By what?

20 MR. DENHOLM: By a new list of drugs  
21 which may be supplied to recipients or rather by a  
22 non-benefit list, a list of drugs which may not be  
23 supplied at benefits.

24 MR. MACLEOD: So that those that are  
25 in that list can be supplied?

26 MR. DENHOLM: May be supplied to wel-  
27 fare recipients as a benefit.

28 MR. MACLEOD: How is the distribution  
29 or supply of such drugs to the welfare recipients  
30



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1 handled?

2 MR. DENHOLM: Through the retail phar-  
3 macists of the Province.

4 MR. MACLEOD: A recipient who receives  
5 a prescription simply takes his prescription to a  
6 retail pharmacy?

7 MR. DENHOLM: Yes. Well, perhaps I  
8 should explain a little more detail.

9 MR. MACLEOD: Yes, if you will.

10 MR. DENHOLM: A particular prescrip-  
11 tion form is used in this case. It is a duplicate  
12 form and the physician prescribes for his welfare  
13 patient and when I use the term "welfare", I should  
14 explain that includes all the old-age pensioners  
15 plus several other indigent groups and the needy  
16 groups in the Province.

17  
18 The prescription, when tendered to  
19 the pharmacist, is filled in the normal way provided  
20 it is within the list of drugs which may be supplied  
21 to these people as benefits. The original copy of  
22 the prescription is in the normal way retained on  
23 the pharmacist's file and the duplicate copy of the  
24 prescription is sent by the pharmacist to the appro-  
25 priate Department of the Government with his monthly  
26 account. Does that answer your question?

27 THE CHAIRMAN: A point has just  
28 occurred to me. You mentioned a new list. Just for  
29 the record, by whom is that new list published or  
30



1 issued?

2 MR. DENHOLM: This new list was drawn  
3 up by a joint committee appointed by the Minister of  
4 Social Welfare of the Province of British Columbia.

5 It consisted of three members of the  
6 B.C. Division of the Canadian Medical Association;  
7 three members of the B.C. Pharmaceutical Association  
8 and the Director of Medical Services of the Depart-  
9 ment of Social Welfare.

10 MR. MACLEOD: Is the cost entirely  
11 borne by the Government?

12 MR. DENHOLM: Is the cost entirely  
13 borne by the Government?

14 MR. MACLEOD: Yes. Is the cost of  
15 these prescriptions entirely borne by the Province?

16 MR. DENHOLM: No. The cost is partly  
17 borne by the Province and partly by the pharmacists.

18 MR. MACLEOD: Perhaps you would just  
19 explain that, if you would?

20 MR. DENHOLM: Yes. The pharmacists  
21 account to the Provincial Government for the pres-  
22 cription service they have supplied through the  
23 means I have just outlined discounted to the extent  
24 of 15% and so the pharmacist is bearing this portion  
25 of the cost of the services.

26 MR. MACLEOD: When you say: he is  
27 bearing that portion of the cost of the services,  
28 he gives a discount of 15% from what he would  
29  
30



1 usually charge?

2 If it was a patient, who had no rela-  
3 tion to welfare, and came in with the same prescrip-  
4 tion, he would pay 15% more than the Government pays  
5 towards the cost of the welfare recipient?

6 MR. DENHOLM: This would vary from  
7 pharmacy to pharmacy. I have no way of knowing  
8 whether it is 15% in every case. This may vary with  
9 the individual, as far as that is concerned.

10 MR. MACLEOD: Do you know whether  
11 there is any generally accepted list for prescrip-  
12 tion prices as used for the purpose of preparing  
13 accounts for the Provincial Government?

14 MR. DENHOLM: For the purpose of pre-  
15 paring these accounts to the Government?

16 MR. MACLEOD: Yes.

17 MR. DENHOLM: Yes, indeed, sir. It  
18 is not a list of prices but it is a price formula  
19 which has been discussed between the Department of  
20 Social Welfare and this Association and is the basis  
21 upon which they will pay. We just advise our members  
22 of the prices upon which the Department will pay.  
23 If they charge more or less --

24 If they charge more they are going  
25 to be deleted to that extent but this is a price  
26 formula upon which the Government will pay, less 15%  
27 discount, of course.

28 MR. MACLEOD: In other words, the  
29  
30



1 Government has established in effect maximum prices  
2 which it will pay in these cases?

3 MR. DENHOLM: That is right.

4 THE CHAIRMAN: Does that mean if the  
5 druggist actually charges somewhat less than on this  
6 list, the 15% will be taken off the price he actually  
7 charges?

8 MR. DENHOLM: There is a provision in  
9 the agreement between the Association and the Govern-  
10 ment or rather, a direction from the Government to  
11 the Association, as to the maximum prices before  
12 calculating the discount of 15%. In no case must the  
13 price charged to the Government exceed that charged  
14 to the public so there is a variation there, sir, an  
15 individual variation between pharmacists.

16 THE CHAIRMAN: I can see how you get  
17 the maximum prices. What I was wondering was: if a  
18 druggist should submit an account at a price that was  
19 below the suggested price, would the 15% be taken off  
20 the price that he shows?

21 MR. DENHOLM: Yes, indeed, sir.

22 THE CHAIRMAN: So that he would be  
23 giving away in a sense more than he needed to?

24 MR. DENHOLM: Yes, indeed, sir.

25 MR. MACLEOD: You have seen the Green  
26 Book, I presume?

27 MR. DENHOLM: I have indeed, sir.

28 MR. MACLEOD: Are these facts or  
29  
30





1 alleged facts put out by the Director in paragraphs  
2 168, 169, 170, 171 through to 173, which begins on  
3 page 97 at 168 - my question is: has the Director  
4 there correctly summarized the situation which exists  
5 in British Columbia or are there any comments or  
6 corrections that you would like to suggest?

7 MR. DENHOLM: 168 is the starting  
8 point, sir?

9 MR. MACLEOD: Yes, on page 97.

10 MR. DENHOLM: Well, paragraph 168, I  
11 cannot really comment on that, sir. This has to do  
12 with the method used by a private company which  
13 publishes a pricing book service and sells it to our  
14 members.  
15

16 MR. MACLEOD: Yes. Well, I thought  
17 you did prepare a document that is --

18 MR. DENHOLM: Just a moment.

19 MR. MACLEOD: Yes, all right.

20 MR. DENHOLM: Still referring to 168;  
21 we, needless to say, know what the formula was used  
22 by this Drugs Bulletin Service, which is the commer-  
23 cial firm referred to and thus from first glances,  
24 sir, I do not have the old formula but the formula  
25 would appear to fairly accurately indicate what was  
26 at one time the pricing formula used by the druggists'  
27 bulletin service.

28 MR. MACLEOD: Well, I realise that  
29 you do not have detailed knowledge of this but  
30





1 insofar as you do have knowledge of the matters  
2 covered in the paragraph I have mentioned, is the  
3 information set out in the paragraphs correct?  
4

5 MR. DENHOLM: 168 is not current, sir.

6 MR. MACLEOD: What is the present  
7 situation?

8 MR. DENHOLM: I am afraid you would  
9 have to get the details of that from the service.  
10 I don't know the details of it. I am advised by  
11 some of our members this system has been changed.  
12 I don't know the details.

13 THE CHAIRMAN: Do you know when it  
14 was changed, approximately?

15 MR. DENHOLM: No, I don't, sir. I  
16 am sorry.

17 MR. MACLEOD: Changed in what sense?  
18 Is the druggists' bulletin service still issued?

19 MR. DENHOLM: Yes sir. It is still  
20 for sale to pharmacists in British Columbia, and I  
21 believe, in Alberta.

22 MR. MACLEOD: The formula used in  
23 computing the suggested retail price has been  
24 changed. Is that what you are saying?

25 MR. DENHOLM: That is the information  
26 we have received from some of our members.

27 MR. MACLEOD: You yourself are not in  
28 a position to give the details of such changes?  
29

30 MR. DENHOLM: No sir.



1  
2 MR. MACLEOD: You suggest in your brief  
3 that your Association is not concerned with the matter  
4 of selling prices by retail pharmacists.

5 MR. DENHOLM: Not concerned with the  
6 matter of selling prices?

7 MR. MACLEOD: Yes, resale prices to  
8 the public.

9 MR. DENHOLM: That is correct, sir.

10 MR. MACLEOD: You suggest, I think,  
11 that no pressure is exerted by your Association?

12 MR. DENHOLM: That is correct, sir.

13 MR. MACLEOD: I am not suggesting for  
14 a moment that there was any intent to infringe the  
15 law. I think it is pretty obvious that it was not  
16 but nevertheless, is it not a fact that you had a  
17 committee working for some years trying to bring out  
18 a uniform schedule for prescription prices?

19 MR. DENHOLM: A uniform schedule?

20 MR. MACLEOD: Bring out a suggested  
21 schedule for prescription prices.

22 MR. DENHOLM: No sir, not to bring  
23 out -- may I elaborate?

24 MR. MACLEOD: Yes, surely.

25 MR. DENHOLM: Not to bring out a  
26 suggested scale of prescription prices. We have had  
27 a committee for some time working on an investigating  
28 the principles of professional fees and there has  
29 been discussion regarding that professional fee and  
30



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1 how its more widespread use may be encouraged amongst  
2 the members but to my knowledge, there has never been  
3 a suggestion that we print a suggested price schedule.  
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1 MR. MACLEOD: Wasn't the Committee  
2 of your Association working on that very thing when  
3 you obtained legal advice it was against the legal  
4 and constituted provisions of a Combines Act?  
5

6 MR. DENHOLM: No sir, not at all.  
7 The committee at that time was investigating a plan  
8 which became popularly known as the Rosen Plan which  
9 was a method, a different method of computing profes-  
10 sional service fees. The Committee investigated  
11 this very thoroughly. The whole concept was  
12 completely different to the normal concept of pres-  
13 cription pricing which has prevailed for many years.  
14 As a result the Committee or representatives of the  
15 Committee attended meetings in various areas of the  
16 Province to see how the pharmacists felt about this.  
17 This is all sounding out until they discovered how  
18 the pharmacists felt about it. They then reported  
19 into the Committee and the Committee then said, well,  
20 this is an alternative to the method of computing  
21 professional fees. Let's suggest it.  
22

23 MR. MACLEOD: Yes.

24 MR. DENHOLM: And they suggested it  
25 and we sought the advice of our solicitor and he  
26 advised us in spite of the fact that this was a new  
27 method of computing professional fees since it had  
28 to do with purchase of goods as well as services in  
29 his view it constituted, if the Association adopted  
30 it or put forward it or attempt to promote it, it



1 would be improper. Upon receiving that advice, of  
2 course, we scrapped the plan, sir.

3 MR. MACLEOD: Your recollection is  
4 that pertaining this only to the Rosen Plan and not  
5 to the more general subject of obtaining a suggested  
6 list of prescription prices?  
7

8 MR. DENHOLM: Well, sir, certainly  
9 in the various meetings of this Committee over the  
10 years all sorts of suggestions have been made by  
11 individual members of the Committee and these members  
12 are individual pharmacists.

13 MR. MACLEOD: Yes.

14 MR. DENHOLM: They all have different  
15 views. We don't for a moment stop them from expres-  
16 sing their own views, in fact, we encourage them to  
17 express their views but their views are very carefully  
18 checked before any action is taken on the part of any  
19 Committee, very carefully subjected to the scrutiny  
20 of the Council and if anything improper is being  
21 contemplated they are stopped. This is not to say  
22 the Committee has not discussed such matters. Of  
23 course they have, sir.

24 MR. MACLEOD: I was going to suggest  
25 to you that the proposal put forward by various  
26 members would be in connection with the suggestions  
27 for a uniform scale or suggested uniform scale of  
28 professional fee? Is that not the objective that  
29 was in the mind of everyone in their discussions?  
30





1 MR. DENHOLM: In the mind of everyone,  
2 no sir.

3 MR. MACLEOD: Perhaps you can't say  
4 that. Wasn't the general purpose of the Committee  
5 and everyone...

6 MR. DENHOLM: It certainly wasn't the  
7 general purpose of the Committee. I think we are  
8 mixing two questions, Mr. Chairman. If I may sepa-  
9 rate them, the purpose of the Committee was as out-  
10 lined in the Terms of Reference issued to the Commi-  
11 tee for several different years and I believe some of  
12 them are on your file. The purpose of the Committee  
13 was to establish, to discuss the field of professional  
14 fees and to do everything within the law to encourage  
15 the widespread acceptance by pharmacists of the prin-  
16 ciple of charging professional fees.

17 To go back to the other half of your  
18 question, sir, some persons - some members of these  
19 committees put forward the views you said, yes indeed.  
20 They are individual pharmacists and like most people  
21 are individualists and they have their beliefs. They  
22 come to Committee meetings and express them. If  
23 these beliefs are without the law or further if to  
24 promote these beliefs and to formulate them into the  
25 programme were without the law they were stopped, sir.  
26 Of course they expressed their opinions.

27 MR. MACLEOD: Wasn't it the purpose  
28 of these Committees to arrive at a professional fee  
29  
30





1 which could be suggested for the use of all pharma-  
2 cists? I am not suggesting for a minute there was  
3 any obligation on the pharmacists to follow it but  
4 wasn't the idea to get a particular fee and recommend  
5 its use?  
6

7 MR. DENHOLM: As an amount, sir?

8 MR. MACLEOD: Yes.

9 MR. DENHOLM: No sir. The purpose of  
10 this Committee as outlined in several years in a row  
11 in its Terms of Reference was to encourage - I think  
12 I can give you almost completely - to encourage the  
13 widespread adoption of the principle of a professional  
14 fee.  
15

16 MR. MACLEOD: Does that mean there  
17 were many pharmacists in the opinion of the Associa-  
18 tion who were not charging a professional fee?  
19

20 MR. DENHOLM: There are some, of  
21 course. How many - a great many, I wouldn't care to  
22 give a figure.  
23

24 MR. MACLEOD: Does the Committee feel  
25 it is a problem? Does the Association feel it is a  
26 problem it would set up a Committee to deal with?  
27

28 MR. DENHOLM: Well, Mr. Chairman, we  
29 spent several pages here outlining what in our view  
30 were the justifications and the reasons for a pharma-  
cist charging a professional fee for the services he  
renders. The Director too in the Green Book touched  
upon a few others. Obviously, sir, since we have



1 presented these factors to the Commission we believe  
2 them.

3  
4 THE CHAIRMAN: I understand the ques-  
5 tion to be whether it was a problem you felt required  
6 a Committee to...

7 MR. DENHOLM: I am coming to it. We  
8 believe in them. If we do believe them it therefore  
9 follows that we should take these beliefs to our  
10 members and try and express it to them and we  
11 expressed it to them by terms of saying we believe  
12 you provide these professional services as outlined  
13 and we believe you are justified in charging a fee  
14 for these services completely independent of your  
15 cost of goods.

16  
17 MR. MACLEOD: What is your Committee  
18 called, Mr. Denholm?

19 MR. DENHOLM: Professional Fees  
20 Committee.

21 MR. MACLEOD: I suggest to you you  
22 had a Committee at various times called the Pres-  
23 cription Pricing Committee.

24 MR. DENHOLM: It was before my time  
25 in the Association, sir.

26 MR. MACLEOD: You recall giving me  
27 the Minutes of one of the meetings?

28 MR. DENHOLM: Yes.

29 MR. MACLEOD: This, of course, will  
30 be before the Commission. It will be quite clear.



1 MR. DENHOLM: Excuse me just a minute.  
2  
3 Mr. Chairman, could I have the serial number to  
4 which you refer?

5 MR. MACLEOD: No, I am afraid I don't  
6 have the document with me. I have taken the bare  
7 minimum that would carry me along. I don't have  
8 your document with me.

9 MR. DENHOLM: This reference to a  
10 Prescription Pricing Committee was in the material  
11 you got from the Association?

12 MR. MACLEOD: It is my impression it  
13 was, but I suggested there is no use of our arguing  
14 or discussing it because the material will be  
15 before the Commission.

16 MR. DENHOLM: I have been through the  
17 material you have collected, sir, and I believe you  
18 are mistaken.

19 MR. MACLEOD: As I say...

20 THE CHAIRMAN: I don't think we will  
21 pursue this further.

22  
23 MR. HINKSON: Perhaps my friend has  
24 reference to the negotiations with the Provincial  
25 Government in connection with welfare patients.

26 MR. DENHOLM: This might well be the  
27 case, Mr. Chairman. In negotiations with the Provin-  
28 cial Government on behalf of our members to set up  
29 the supplying of drugs and pharmaceuticals to welfare  
30 recipients which I just described there may well have



1 been a part of this social service committee which  
2 dealt specifically with the prices that were under  
3 discussion between the Government and ourselves at  
4 that time.

2  
6 MR. MACLEOD: You have already told  
7 us of one instance, do you know of other instances  
8 in the past where the prices listed in the Druggists'  
9 Bulletin Service being revised was based, quoted  
10 according to an amended formula?

11 MR. DENHOLM: I am afraid I can't give  
12 you that information, sir. I don't have their  
13 changes catalogued.

14 MR. MACLEOD: Do you know if, in fact,  
15 members of your Association were polled by the  
16 publishers of D.B.S. to determine if certain changes  
17 were acceptable to them or if they desired certain  
18 changes?

19  
20 MR. DENHOLM: That question would imply  
21 all members of the Association. We received a copy  
22 of a questionnaire that was sent out by the Druggists'  
23 Bulletin Service and we received no further informa-  
24 tion from them. It was my understanding it was only  
25 sent to their subscribers.

26 MR. MACLEOD: To their subscribers.

27 MR. DENHOLM: I may be incorrect, sir.  
28 That was my understanding.

29 MR. MACLEOD: You, of course, are not  
30 able to speak to the mechanics of changes or reasons



1 for changes?

2 MR. DENHOLM: No.

3 MR. MACLEOD: There is no use pursuing  
4 that. Does the Association publish a set of by-laws?

5 MR. DENHOLM: Yes sir.

6 MR. MACLEOD: Do you recall if you  
7 supplied me with a copy when I was out here?

8 MR. DENHOLM: We have copies here, sir.  
9 I believe we gave you a copy.

10 MR. MACLEOD: I may have it in Ottawa.

11 MR. HINKSON: I have a copy here you  
12 are welcome to.

13 MR. MACLEOD: We will put this in as  
14 part...

15 MR. HINKSON: If you wish copies we  
16 can furnish additional copies to the Commission.

17 THE CHAIRMAN: If there are any points  
18 going to be discussed this morning we would like to  
19 have the by-laws so we can refer to the actual  
20 language in the by-laws.

21 MR. MACLEOD: No, I would have to  
22 read these through before asking any questions. I  
23 want to get them in as part of the record.

24 THE CHAIRMAN: There is no harm in  
25 having it in. We would certainly want it, but if  
26 it was going to be discussed, if anything turns on  
27 it we should have it. I think the best thing is to  
28 identify it and put it in as an exhibit.  
29  
30





1  
2 MR. MACLEOD: I was going to ask the  
3 witness if he could identify this as being the by-laws  
4 of British Columbia.

5 MR. DENHOLM: There are two sets of  
6 by-laws. The first are the by-laws of the Association  
7 and the second are the by-laws of the Council. The  
8 by-laws of the Association have to do almost exclu-  
9 sively with the election of councillors and the  
10 outlining of electoral districts and so on. The  
11 by-laws of the Council are those by-laws which have  
12 been enacted under the Section of the Act referred to  
13 in the brief, Section 9, I believe it is, sir. Yes.

14 MR. MACLEOD: Perhaps we could it  
15 marked.

16 THE CHAIRMAN: We will mark these as  
17 one exhibit, Van-1.

18  
19  
20 --- EXHIBIT NO. VAN-1: By-laws of Association and  
21 by-laws of Council.

22 MR. MACLEOD: Have you written articles  
23 or made speeches about the qualities of brand name  
24 products as opposed to qualities of generic products  
25 and have such articles or speeches been printed in  
26 the trade journals of the drug industry?

27 MR. DENHOLM: I have written or given  
28 speeches on some occasions regarding the quality of  
29 drugs and the differences which exist as to quality  
30





1 between manufacturer and manufacturer. It is my  
2 recollection that I have never given a speech in  
3 which I have directly referred to brand or generic  
4 names, sir, not in those terms. I may have referred  
5 to the terms but the address has been concerned with  
6 the quality of the drugs produced by various manufac-  
7 turers.  
8

9 MR. MACLEOD: Haven't you consistently,  
10 sir, said the brand name products, large manufacturers,  
11 are superior to any other products on the market?

12 MR. DENHOLM: No sir, I have taken the  
13 stand that in many cases brand name products are pro-  
14 duced by companies who exercise quality control proce-  
15 dures. I haven't at any time said this applies to  
16 all brand name products nor it doesn't apply to those  
17 which are not brand name. As stated in the brief we  
18 hold no views of the large companies or small compa-  
19 nies or how old they are or how young they are,  
20 whether they attach a brand name to their products  
21 or not. It has been my consistent effort to state  
22 that quality must be the prime consideration in the  
23 dispensing of drugs.  
24

25 MR. MACLEOD: Yes.  
26  
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Haven't you berated the generic drug houses as being coat-tail riders, copyers, imitators and so on, for publication?

MR. DENHOLM: No sir, although I have appeared in the press to have used some of those terms on occasion.

MR. MACLEOD: You were so quoted, yes.

MR. DENHOLM: Yes.

MR. MACLEOD: But you say now you were misquoted?

MR. DENHOLM: With reference to the names used, coat-tail riders, what were the others?

MR. MACLEOD: And copyers and imitators?

MR. DENHOLM: I have not used those expressions.

MR. MACLEOD: Have you suggested that the generic houses were parasites on the industry, that they do nothing but cash in on the other fellow's success?

MR. DENHOLM: I have not said generic brand name houses.

MR. MACLEOD: If I said that I was confused. Have you suggested that the generic name houses were parasites feeding on the success of the brand name houses that go out and do the work?

MR. DENHOLM: I have said this.



1 That some manufacturers are parasites feeding on the  
2 successes of some other manufacturers. Now, I have  
3 not said it in precisely the way you put it.  
4

5 MR. MACLEOD: You have said it in the  
6 way that you yourself have put it now?

7 MR. DENHOLM: Yes.

8 THE CHAIRMAN: You mean you have not  
9 said that meaning the distinction between generic  
10 and brand name manufacturers?

11 MR. DENHOLM: Precisely.

12 MR. MACLEOD: Insofar as that impres-  
13 sion arises from quotations attributed to you, that  
14 you favour brand name over generic name, you were  
15 misquoted?

16 MR. DENHOLM: Yes.

17 MR. HUME: Perhaps Mr. Macleod would  
18 be good enough to put on the record at this time  
19 the time and place of these quotations, so that we  
20 can check them.

21 MR. MACLEOD: I will very gladly do  
22 that. You will notice I started my examination by  
23 asking the witness if he had been quoted publicly,  
24 and he said he had. I will be glad, as soon as I  
25 get back to Ottawa and have my complete set of docu-  
26 ments in front of me, to give the Commission a list  
27 of the articles and statements by Mr. Denholm.  
28

29 MR. HINKSON: Do I understand my  
30 learned friend to say that these have all appeared



1 in the public press, they are not private communica-  
2 tions?

3 MR. MACLEOD: I was directing his  
4 attention at the moment to alleged public utterances  
5 of Mr. Denholm. As counsel is undoubtedly aware, the  
6 material which will be put before the Commission  
7 includes certain documents selected from the Asso-  
8 ciation office, and in those will be certain expres-  
9 sions of opinion by Mr. Denholm, but I am not refer-  
10 ring to that material at this time.

12 Going back to what we were talking  
13 about a moment ago, I think you told me that your  
14 Association had no concern about the prices that the  
15 retail pharmacist charges, is that correct? Is  
16 that what you told me?

17 MR. DENHOLM: That is correct sir.

18 MR. MACLEOD: Are you opposed to  
19 discount houses?

20 MR. DENHOLM: In what context is the  
21 question asked please?

22 MR. MACLEOD: Well, I see in the Drug  
23 Merchandising for August 1960, this appears: "Doug  
24 Denholm, Registrar of the Pharmaceutical Association  
25 of British Columbia, comments: 'We don't have dis-  
26 count houses as they are known in other parts of  
27 the country, and we want to keep the situation that  
28 way'". When you use "we" there, are you referring  
29 to yourself as an officer of the Association?  
30



1 THE CHAIRMAN: Is that an actual quo-  
2 tation in quotation marks?

3 MR. MACLEOD: It is a quotation attri-  
4 buted to Mr. Denholm, and it appears in the article  
5 in quotation marks.  
6

7 MR. DENHOLM: Yes, a reporter from  
8 this publication, Maclean-Hunter, came in to see me  
9 and we had a long discussion about this, and while  
10 I don't remember the exact words, I certainly read  
11 this shortly afterwards, and I didn't object to the  
12 wording of it.

13 MR. MACLEOD: Did you feel you were  
14 speaking on behalf of the Association?

15 MR. DENHOLM: Yes, I think we should  
16 clarify something here, Mr. Chairman. It appears  
17 to be taken for granted that the objection to dis-  
18 count houses as outlined in this quotation has to  
19 do with prices. That is not so. Discount houses  
20 as we understand them in operation in Eastern Canada  
21 are operated in some parts of Eastern Canada, operate  
22 pharmacies, but they are operated by non-pharmacists.  
23 This is a principle with which we don't agree.  
24

25 MR. WHITELEY: Are you sure that is  
26 the case?

27 MR. DENHOLM: I am not positive of it,  
28 but this is our understanding in some areas.

29 MR. WHITELEY: Which province  
30 permits that?



1 MR. DENHOLM: I believe there is an  
2 ownership clause in the Ontario Pharmacy Act which  
3 permits this.

4 MR. WHITELEY: Permits a non-pharmacist  
5 to sell drugs?

6 MR. DENHOLM: To own a business  
7 selling drugs.

8 MR. WHITELEY: What requirement is  
9 there as to dispensing?

10 MR. DENHOLM: The requirement as to  
11 dispensing certainly is that this must be done by a  
12 pharmacist.

13 MR. WHITELEY: But you regard that  
14 as the sale of drugs by a non-pharmacist, even though  
15 the drug is dispensed by a pharmacist?

16 MR. DENHOLM: No, this is not quite  
17 the point sir. We outline in our brief one of the  
18 sections of the Act provides that a corporation opera-  
19 ting a pharmacy must be pharmacist-controlled, and  
20 the Chairman discussed that with us at some length.

21 THE CHAIRMAN: I think that is the  
22 situation in Ontario. I think it might be another  
23 province, maybe Manitoba.

24 MR. DENHOLM: Yes, I am not positive  
25 on this, but we have been led to believe that this  
26 type of operation is a non-pharmacist operation.

27 MR. WHITELEY: How do you regard  
28 that as a non-pharmacist operation?  
29  
30





1 MR. DENHOLM: If I interpret your  
2 question correctly, it is why is it necessary that  
3 pharmacists own pharmacies? Is this the question?  
4

5 MR. WHITELEY: No, why you regard  
6 the dispensing of a drug by a pharmacist who does  
7 not own the business as the sale of a drug by a non-  
8 pharmacist?

9 MR. DENHOLM: I didn't say that at  
10 all.

11 MR. WHITELEY: I understood you to  
12 say that.

13 MR. DENHOLM: I am afraid you misunder-  
14 stood me.

15 MR. WHITELEY: What is your reference  
16 to non-pharmacists?

17 MR. DENHOLM: To non-pharmacists  
18 owning and operating licensed pharmacies.

19 MR. WHITELEY: What considerations of  
20 public health do you consider are affected by that?  
21

22 MR. DENHOLM: Purely this, as we have  
23 set out at some length in the brief, the responsibi-  
24 lity of the pharmacist and the things he must do to  
25 safeguard the health, and we believe that if the  
26 policy of a pharmacy should also be controlled  
27 within those same precepts, if this were not the  
28 case, if non-pharmacists could operate a pharmacy,  
29 then the pharmacist, notwithstanding the fact he  
30 might be doing the dispensing, would have no control



1 over the operation of the pharmacy.

2 MR. WHITELEY: In what way?

3 MR. DENHOLM: Well, the person who  
4 owns the shop presumably is the boss, and with no  
5 pharmaceutical training he might decide to do any-  
6 thing that the pharmacist might not like doing, but  
7 would have to do simply because he was employed.

8 MR. WHITELEY: What are some specific  
9 dangers that you can see?  
10

11 MR. DENHOLM: I couldn't go into a  
12 list of specific dangers.

13 MR. WHITELEY: Well, an example?

14 MR. DENHOLM: I think it is possible  
15 that a non-pharmacist owner of a pharmacy might well  
16 direct that the cheapest of drugs be used at all  
17 times, placing economic considerations ahead of  
18 quality, whereas the pharmacist would never make  
19 that decision. I am not saying it would happen, but  
20 it is a possibility. The pharmacist would never make  
21 that decision, because he is legally and morally  
22 responsible for this drug. Does that answer your  
23 question?

24 MR. WHITELEY: Well, I assume that  
25 the professional pharmacist would have his profes-  
26 sional standards. I don't see how they could be  
27 over-ridden by the ownership of the store.

28 MR. DENHOLM: I would like to believe  
29 that was so sir, but --  
30



1 MR. WHITELEY: Well, in those provinces  
2 that permit this separation of ownership, have you  
3 heard of any cases of unprofessional conduct?

4 MR. DENHOLM: I cannot comment on  
5 the situation in any other provinces sir, no.

6  
7 MR. MACLEOD: Do you regard price  
8 competition in respect of prescriptions as being  
9 unethical?

10 MR. DENHOLM: No.

11 MR. MACLEOD: Does the Association  
12 have any stand on this matter?

13 MR. DENHOLM: None whatsoever sir.

14 MR. MACLEOD: Would you consider it  
15 proper practice for one of your members to advertise  
16 prescriptions 35% off?

17 MR. DENHOLM: Would you say it again  
18 sir?

19 MR. MACLEOD: Would the Association  
20 consider it proper for one of its members to adver-  
21 tise prescriptions 35% off?

22 MR. DENHOLM: Advertise to the public?

23 MR. MACLEOD: To the public.

24 MR. DENHOLM: No sir, they would  
25 take no position in the matter.

26 MR. MACLEOD: That would be perfectly  
27 all right?

28 MR. DENHOLM: To the public, no  
29 position in the matter.  
30



1 MR. MACLEOD: Does your Code of Ethics  
2 make any reference to prices?

3 MR. DENHOLM: No sir.

4 MR. MACLEOD: To reasonable prices  
5 being charged, or anything?

6 MR. DENHOLM: No, in point of fact I  
7 think it should be drawn to the attention of the  
8 Commission that we don't have a specific Code of  
9 Ethics. We use and rely on the Code of Ethics of  
10 the Canadian Pharmaceutical Association, and it is  
11 in that context I answer your question.

12 MR. MACLEOD: Have you on any occasion  
13 that you can recall discussed the selling prices of  
14 prescriptions with any individual druggist in your  
15 official capacity as Registrar of the Association?

16 MR. DENHOLM: Have I at any time  
17 discussed prescription prices with an individual  
18 member of the Association?

19 MR. MACLEOD: Yes, in your capacity  
20 as Registrar.

21 MR. DENHOLM: Officially?

22 MR. MACLEOD: Yes.

23 MR. DENHOLM: Well --

24 MR. MACLEOD: Have you ever gone to  
25 any particular pharmacist and suggested to him that  
26 he should change his prices, or that the pricing  
27 policy he is following is not quite right and  
28 should be changed in some way?



1 MR. DENHOLM: No sir.

2 MR. MACLEOD: Do you know if the  
3 Executive Secretary has ever done that?  
4

5 MR. DENHOLM: I have no knowledge,  
6 but I doubt it very much.

7 MR. MACLEOD: Do you get representa-  
8 tions from your members on occasion that certain  
9 druggists are not following proper pricing prac-  
10 tices?

11 MR. DENHOLM: Very occasionally there  
12 used to be the odd mention of that, but we have  
13 consistently told our members at all times that  
14 the Association has no role in this matter, and  
15 latterly no sir.

16 MR. MACLEOD: That is any complaints  
17 that have come in by one pharmacist against another  
18 have not been acted upon by your Association?

19 MR. DENHOLM: Definitely not sir.  
20 We do receive quite a number what you might call  
21 complaints from the general public, saying to us  
22 that they think this is wrong or that is wrong, but  
23 almost invariably these complaints or comments are  
24 couched in pretty vague and general terms.  
25

26 THE CHAIRMAN: Do you mean that when  
27 complaints come in, either from one pharmacist  
28 about another one's prices, or by some member of  
29 the public about prices, that the Association takes  
30 no action whatsoever of any kind?



3/dpw

1 MR. DENHOLM: There are two questions.  
2 The first with regard to the members; no, no action  
3 whatsoever, sir.

4 With regard to the public, sir, in  
5 the case of general complaints, and those are usually  
6 of a comparative nature, we point out to the person  
7 'phoning that it is the law that that has to be so  
8 and that there be competition and that there be  
9 variation in prices and certainly we are not going to  
10 do anything to defend that.

11 THE CHAIRMAN: The law does not compel  
12 variation in prices.

13 MR. DENHOLM: No, that is right. On  
14 one or two occasions where a person has indicated,  
15 a member of the public 'phoning has indicated and  
16 given a lot of details about prices and indicated  
17 something quite ridiculous in the way of differen-  
18 tials; something that just doesn't seem to make any  
19 sense, we have asked if the person has spoken to  
20 the pharmacist about whom you are complaining to  
21 track this down and usually the answer is "No".  
22 We have endeavoured to persuade them to go back  
23 because if this is a case of error, it will be  
24 remedied.

25 MR. MACLEOD: Now, I think you said  
26 in your brief on page 8 - I don't where on page 8  
27 but in some place you make a reference to the two  
28 functions of the pharmacist being inextricably  
29





1 entwined.

2 MR. DENHOLM: Yes.

3 MR. MACLEOD: That is the economic  
4 and health?

5 MR. DENHOLM: Yes.

6 MR. HINKSON: I am sorry. That is  
7 the wrong context, with respect. I believe it was  
8 business and professional.

9 MR. WHITELEY: At the top of page 7.

10 MR. MACLEOD: Do you not think it is  
11 undesirable that the people who should profit through  
12 a change in the laws are the ones who would recommend  
13 that change in the laws? For instance, if a certain  
14 drug is only being sold in drugstores, obviously  
15 that is to the advantage of the drugstores, is that  
16 not right? Is it not rather unsatisfactory to have  
17 the recommendation in respect to the sale of that  
18 drug made by the druggists?

19 MR. DENHOLM: If it were so made, yes,  
20 presumably there may be some room to --

21 MR. MACLEOD: Is it not on the recom-  
22 mendation of the Council, as I think you said in  
23 your brief, that changes in these schedules are made?

24 MR. DENHOLM: Yes, indeed. I think  
25 you are misconstruing, Mr. MacLeod. The Chairman,  
26 the principle section of the schedules to which I  
27 have referred and which have been constantly amended  
28 here, is Schedule A, Part 1 and this sir starts on  
29  
30



1 page 3543 of the brief there.

2 This is a list of drugs which may  
3 only be sold by the pharmacist on the prescription  
4 of a physician, dentist or veterinary surgeon and  
5 this list is, in fact, amended three or four times  
6 a year easily.

7 Now, it is erroneous to state that  
8 the pharmacists do this.

9 Firstly, the recommendations are  
10 received as to new drugs which have come on the  
11 market and they are considered for inclusion on  
12 the schedule. If after consulting the Department  
13 of Pharmacology or the Faculty of Pharmacy at the  
14 University of British Columbia this suggestion is  
15 upheld, then this is placed before the Council as a  
16 resolution.

17 If Council then pass it, it goes to  
18 the Lieutenant-Governor-in-Council, in effect, the  
19 Provincial Cabinet. It is perused by the entire  
20 Health Department, by the Deputy Minister and his  
21 assistants before it is approved; so that control  
22 does not lay with the pharmacists. The control lies  
23 with the Provincial Department of Health. We start  
24 the ball rolling, yes.

25 As to your implication that this is  
26 improper in view of the fact that you seem to  
27 gather that this gives the pharmacists some benefit;  
28 in point of fact directly the opposite is true.



1 For example, Mr. Chairman, your trans-  
2 cript in Ottawa when you were meeting with Dr. Morrell,  
3 mentioned amongst other things the fact that in 1958,  
4 I believe it was, the sale of 28 tranquilizers had  
5 been added to Schedule F of the Food and Drugs Act.  
6

7 In point of fact, sir, they were on  
8 Schedule A, Part 1 of the B.C. Act two years before  
9 this because it was our feeling, and this feeling was  
10 substantiated by the Provincial Department of Health,  
11 that these drugs were open to abuse so they were  
12 restricted in this Province and prescription sold  
13 only, long before they were restricted in the rest of  
14 Canada.

15 Far from being an economic advantage  
16 to the pharmacist, sir, this was a definite economic  
17 disadvantage to the pharmacist.

18 The sale of these drugs, while they  
19 were restricted in British Columbia, and open for  
20 sale across the counter in other parts of the country,  
21 was substantially less than it was in the other parts  
22 of the country. So here the pharmacists, acting  
23 through their collective organization, have in fact --

24 MR. MACLEOD: Cut their business.

25 MR. DENHOLM: Cut their business in  
26 the interest of public health. I think, sir, with  
27 all due respect your suggestion that the opposite is  
28 done is most improper.  
29

30 MR. MACLEOD: I was thinking more of



1 having the sale of articles in drugstores. For  
2 instance, I take it there are not two standards  
3 that operate in this Province. One five miles within  
4 a drugstore and one five miles away from a drugstore;  
5 surely not. Isn't the only purpose of Part 2 of  
6 Schedule B to confine the sale of certain drugs to  
7 drugstores in the metropolitan and general areas?

8 MR. DENHOLM: Well, no. I think can  
9 we go back a little bit on this, Mr. Chairman? You  
10 will note in Part 3 of Schedule A in addition to the  
11 specific drugs mentioned, that is at page 3548, Mr.  
12 Chairman.  
13

14 THE CHAIRMAN: Yes.

15 MR. DENHOLM: In addition to the  
16 specific drugs mentioned through 1 to 49, there is  
17 a general classification of all drugs included in the  
18 definition clause of this Act. New lists, new drugs  
19 approved by legislation, etc. This covers all drugs  
20 in effect by definition.

21 The purpose of Schedule B is to  
22 create exemptions to that restriction. Schedule B,  
23 Part 1 creates a general release. Schedule B, Part  
24 2 creates a partial release of a few things that I  
25 doubt very much are sold now anyway.

26 I will be quite prepared to concede,  
27 Mr. MacLeod, that perhaps Part 2 of Schedule B,  
28 being little-used drugs which are not open to any  
29 improper uses, they might well be amended.  
30



1 MR. MACLEOD: Is it not true generally  
2 that the pharmacist, perhaps for perfectly valid  
3 reasons, tries to channel the sale of as many pro-  
4 ducts as possible through the drugstores?

5 MR. DENHOLM: As many drug products?

6 MR. MACLEOD: Yes.

7 MR. DENHOLM: Of course, sir.

8 MR. MACLEOD: Is it not the policy of  
9 certain pharmacy manufacturers in only channelling  
10 their products through drug outlets to more or less  
11 curry favour with the pharmacists?

12 MR. DENHOLM: Well, sir --

13 MR. MACLEOD: Isn't it in response  
14 from a demand by the pharmacists that this be done  
15 that this policy is followed?

16 MR. DENHOLM: Mr. Chairman, I would  
17 not presume to answer on behalf of the Canadian  
18 pharmaceutical manufacturers but I would fear to  
19 doubt that the policy on the part of some manufac-  
20 turers, had anything to do whatsoever with currying  
21 favour with the pharmacists, as Mr. MacLeod puts  
22 it.

23 Rather, I would assume that the  
24 manufacturers concerned view the pharmacy as a  
25 desirable place of business in which to have his  
26 products offered for sale and generally speaking, I  
27 believe it is right to say that the standards of  
28 pharmacy across the country are high, the standard  
29  
30





1 of selling procedures and the standard of control is  
2 high.

3 I believe manufacturers will feel  
4 this that it is the kind of establishment in which  
5 they would want their products sold.

6 I can see no reason why they should  
7 do this to curry favour with the pharmacists.

8 MR. MACLEOD: Do you know if your  
9 Association has made any representations to any  
10 manufacturer whatsoever they should confine the sale  
11 of any product to drugstore outlets in British Colum-  
12 bia?  
13

14 MR. DENHOLM: Not to my knowledge, sir.

15 MR. MACLEOD: Do you recall anything  
16 in connection with Pabulum a number of years ago?

17 MR. DENHOLM: Yes sir.

18 MR. MACLEOD: What was done in that  
19 case?

20 MR. DENHOLM: By the Association?

21 MR. MACLEOD: Yes.

22 MR. DENHOLM: Nothing, sir.

23 MR. MACLEOD: Did the Association  
24 support the action of the Canadian Pharmaceutical  
25 Association in urging that Pabulum only be sold  
26 through drugstores?  
27

28 MR. DENHOLM: Not actively, sir, no.

29 Since this Association is by consti-  
30 tutional right a member of the C.P.A., I suppose we





1 are in effect associated with that but we certainly  
2 did not actively associate ourselves with it.

3 MR. MACLEOD: Do you recall whether  
4 there was any discussion of the Pabulum issue in  
5 your Association or by any committees thereof?

6 MR. DENHOLM: No sir. I recall a  
7 good deal of individual discussion by various pharma-  
8 cists. I was in practice myself at that time.

9 MR. MACLEOD: You were not associated  
10 with the Association at that time?

11 MR. DENHOLM: No.

12 THE CHAIRMAN: Mr. MacLeod, will you  
13 be a little while yet? It is just after half-past  
14 twelve. If you are going to be a while longer and  
15 perhaps Mr. Hinkson will have some questions, I  
16 think we had better adjourn for lunch.

17 MR. MACLEOD: I really do not know  
18 how long I will be, sir, because I didn't see the  
19 brief until this morning.

20 THE CHAIRMAN: I think we will adjourn  
21 now until 2.15 p.m. Is that satisfactory to you?

22 MR. HINKSON: Quite satisfactory, Mr.  
23 Chairman.

24 --- The hearings recessed until 2.15 p.m.  
25  
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E/dpw

1 --- On resuming at 2.15 p.m.

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MR. HINKSON: Mr. Chairman, before my friend resumes his cross-examination, this morning he cross-examined this witness in relation to certain newspaper articles apparently of speeches given by the witness from time to time. I understood him to say he didn't have those documents with him and I think it is usual in this type of cross-examination to put the document to the witness. However, I didn't raise any objection. I let him go ahead. I also understand when the Commission returns to Ottawa he intends to produce certain other documents. I gather it was correspondence taken from the files, or copies taken from the files of this Association and put those to the Commission in Ottawa. I understand he doesn't have those documents with him. I am frankly surprised Mr. MacLeod has come all the way to Vancouver without the documents that he wishes to put before the Commission because, I think, in fairness to this Association if he wishes to put in documents taken from the files of the Association or copies of documents that he should produce those documents and put them to the witness. As I understand it at the opening of the Commission at Ottawa it was made quite clear on the record that the statements contained in the Green Book were merely statements of opinion gathered by the Director and



1 that the purpose of this hearing at this time was to  
2 substantiate those statements.

3 THE CHAIRMAN: Not necessarily substan-  
4 tiate.

5 MR. HINKSON: Insofar as they may be  
6 substantiated by the facts. I understand you are here  
7 today to obtain facts insofar as you may in British  
8 Columbia and the purpose in coming here today and  
9 making this submission was to assist you in obtaining  
10 these facts. I think in fairness to the Association  
11 if my learned friend wishes to put in documents taken  
12 from the files that the proper way is to put them to  
13 the witness in order that he may identify them and he  
14 may qualify them if necessary, or explain them if  
15 necessary, but to have some opportunity to comment  
16 upon them otherwise I would think it was most unfair,  
17 Mr. Chairman, to travel all the way to Vancouver and  
18 never produce or refer to the documents and then  
19 travel back to Ottawa and there produce them and put  
20 them before the Commission. That will not be obtain-  
21 ing the facts in my submission, Mr. Chairman.

22 MR. MACLEOD: Mr. Chairman, perhaps  
23 I should mention the first difficulty in dealing  
24 with the documents is that I have now run into my  
25 third full filing case of documents. It was practi-  
26 cally a physical impossibility to freight them  
27 between each place when they wouldn't be required,  
28 at least a portion of them wouldn't be required.  
29  
30



1                   The statement itself in Paragraph 9  
2 reads: "In connection with prescription pricing prac-  
3 tices, besides general inquiries as to the practices  
4 in each Province, specific inquiries were made in  
5 two Provinces, Ontario and British Columbia. In the  
6 course of these, the records of the Ontario College  
7 of Pharmacy and of the Pharmaceutical Association of  
8 the Province of British Columbia were examined and  
9 certain of the records were copied and form part of  
10 the evidence being put before the Commission."

11               In other words the Director gives  
12 notice to anyone reading this and particularly to  
13 the Association of British Columbia that the docu-  
14 ments taken from the files and copied would be put  
15 before the Commission. I tried this morning, I  
16 don't know if I succeeded - I had no intimation as  
17 to who was appearing on behalf of this Association.  
18 I suspected it might be Mr. Denholm. I had no inti-  
19 mation what was being urged in their brief. It did  
20 occur to me after Mr. Denholm had read his brief  
21 into the record there might possibly be a conflict  
22 between the attitude taken in the brief and the  
23 attitude which, according to my recollection, as  
24 shown by certain public statements made by Mr. Den-  
25 holm. I expressly asked him about that and he  
26 explained to the Commission what his attitude was,  
27 what he had intended to convey on the occasions on  
28 which he had spoken publicly, in which his remarks  
29 were made public. It seems to me this situation is  
30



1 reasonably clear.

2 My learned friend, Mr. Hume, our  
3 counsel for the Association...

4 THE CHAIRMAN: Mr. Hinkson.

5 MR. MACLEOD: Suggested those things  
6 be produced, the documents in question, the public  
7 documents of Mr. Denholm and that suggestion having  
8 been made I am perfectly willing to comply with it.  
9 In fact, those statements will probably form part of  
10 the mass of evidence in support of those statements  
11 which will be put before the Commission.

12 MR. HINKSON: That doesn't answer my  
13 objection at all because he is not producing the  
14 statements here. He is going back to Ottawa to  
15 produce them. Certainly Paragraph 9 of the state-  
16 ment of the Director would not suggest statements  
17 made by Mr. Denholm, that is, public speeches were  
18 forming any part of the record here. Frankly, I did  
19 not gather all the documents taken from the Associa-  
20 tion's files in British Columbia were also going to  
21 form part of this record.

22 THE CHAIRMAN: Some of the documents,  
23 certain of the documents.

24 MR. HINKSON: Certain are expressly  
25 referred to and extracts quoted in the course of the  
26 statements.

27 THE CHAIRMAN: Certain of the records  
28 were copied and formed part of this record.  
29  
30





1 MR. HINKSON: For example on page 12  
2 there is reference to a particular document. The  
3 serial number is given, Serial No. 298, at the bottom  
4 of page 12, Mr. Chairman. I took the contents of  
5 paragraph 9 to refer to this type of document quoted  
6 right in the statement. If my friend is going to  
7 produce all the statements taken from the Commission's  
8 offices...

9  
10 THE CHAIRMAN: He said certain of them.

11 MR. HINKSON: I understood him to say  
12 he would tender all the documents to the Commission.

13 THE CHAIRMAN: Perhaps Mr. MacLeod -  
14 do you mean all the documents that came from the  
15 Pharmaceutical Association of B.C. or only certain of  
16 which that you had in mind?

17 MR. MACLEOD: All the documents which  
18 appear to be relevant and which will assist the Commis-  
19 sion which are now in the possession of the Director  
20 will be placed before the Commission.

21 THE CHAIRMAN: Perhaps it might be  
22 desirable then - I don't think we can come back to  
23 British Columbia for the purpose of having these  
24 documents produced, but perhaps we could take this  
25 position: these documents will be brought to the  
26 attention of the Association and Mr. Hinkson as  
27 counsel and a written submission could be made with  
28 respect to them if felt desirable.

29  
30 MR. HINKSON: I regret very much that





1 is going to happen, not we won't have an opportunity  
2 to answer them but I still can't get over the fact  
3 my learned friend has travelled out here knowing he  
4 was going to do this.

5 THE CHAIRMAN: I think he did not know  
6 he was going to do it. He didn't know who was going  
7 to be in the witness box. He wasn't calling witnesses.

8 MR. HINKSON: That is so. As I under-  
9 stand it in other places the Commission itself has  
10 requested certain individuals to come forward and to  
11 give evidence before the Commission.

12 THE CHAIRMAN: We have asked them if  
13 they would be prepared to come forward.

14 MR. HINKSON: It just places me in this  
15 position, we are not going to have satisfactory oppor-  
16 tunity to deal with the documents that my learned  
17 friend wishes to produce. He obviously has certain  
18 ones in mind. I would like to have him put them to  
19 Mr. Denholm. We have the originals which were returned  
20 to us by Mr. MacLeod. If he wishes to cross-examine  
21 Mr. Denholm with respect to these documents, with  
22 respect, Mr. Chairman, I think this is the opportunity  
23 to do so.

24 MR. MACLEOD: I haven't cross-examined  
25 him with respect to any document.

26 THE CHAIRMAN: No.

27 MR. MACLEOD: I have asked about  
28 published statements. I had to lay the basis, if he  
29  
30



1 had made some public statements. He said he had. I  
2 asked what he was trying to express and he explained  
3 to the Commission what he was doing.

4 THE CHAIRMAN: If Mr. MacLeod doesn't  
5 cross-examine you, of course, have a right to.

6 MR. HINKSON: What alarmed me, Mr.  
7 Chairman, was the suggestion my friend made this  
8 morning that when he returned to Ottawa he was then  
9 going to produce documents and put them before the  
2 10 Commission, tender them at that time rather than now.  
11 That is what directed my attention to this matter.

13 THE CHAIRMAN: If no questions are  
14 going to be asked it won't make much difference.  
15 You may ask questions if you feel it necessary, if  
16 you feel there are things in these documents which  
17 should be explained or discussed.

18 MR. HINKSON: I realise that. You  
19 realise I am rather in the dark as to which one my  
20 learned friend wishes to produce, which ones he  
21 thinks are significant from his point of view. I  
22 am in the dark on that. We have the file here of  
23 the documents he has the copies of.

24 THE CHAIRMAN: I think you may take  
25 it, certainly we take it the Green Book sets out  
26 the major matters of factual information which the  
27 Director obtained and the matters which he thought  
28 were of any real importance. Where he refers to a  
29 group of documents apart from that I think they are  
30



1 looked on as being more or less of secondary support-  
2 ting value. That is the impression I have drawn  
3 from that.

4 MR. HINKSON: I just don't know what  
5 significance, if any, my learned friend will attempt  
6 to attach to a particular document of the number of  
7 documents he has.

8 THE CHAIRMAN: If it is referred to  
9 specifically, of course, you know those.

10 MR. HINKSON: Those are simple to  
11 deal with. It is the other ones to which no express  
12 reference was made.

13 THE CHAIRMAN: If nothing was said  
14 about them perhaps he doesn't put too much signifi-  
15 cance on them.

16 MR. HINKSON: If he wishes to I would  
17 like him to do it here rather than at Ottawa so we  
18 will have an opportunity to deal with it.

19 MR. MACLEOD: I might direct the  
20 Commission again to paragraph 11 which deals with  
21 this matter also: "Information was obtained from  
22 many other sources including the Transcript of the  
23 evidence given before the United States Senate Sub-  
24 committee on Antitrust and Monopoly (Kefauver Com-  
25 mittee), trade journals, press reports, industry  
26 price books, technical reference books, and the like,  
27 and by informal interviews with public officials,  
28 doctors, and persons connected with the drug trade.  
29 Where any specific information so obtained is  
30 referred to in the Statement, the source from which



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it was obtained is indicated."

1 This is the part I particularly want  
2 to stress. I think it bears on what we are conside-  
3 ring now.

4 "The Commission will be asked to  
5 consider various trade journals as illustrative of  
6 general conditions in the field such as the number  
7 of new drugs and compounds introduced each year, the  
8 type of advertising published by the manufacturers,  
9 the types of "deals" and special discounts offered  
10 from time to time, comment by those in the trade on  
11 various matter, and the like."

12 We will be putting before the Commis-  
13 sion in due course making available for the Commis-  
14 sion's examination copies of Drug Merchandising  
15 published by Maclean-Hunter, copies of the Canadian  
16 Pharmaceutical Journal and copies of the Western  
17 Druggist over the past several years, that we feel  
18 will be of real assistance to the Commission to know  
19 what the trade and those concerned with the trade  
20 have to say about it. I am sorry that at the moment  
21 I can't specifically point to the places where Mr.  
22 Denholm is quoted. It is my understanding and my  
23 recollection he is quoted not only in the newspaper  
24 but by certain drug journals as well. In fact, I  
25 directed his attention to one such instance this  
26 morning in connection with discount houses, where  
27 he was specifically quoted in a trade journal.

28 MR. HUME: May I just interject to  
29 say what my friend, Mr. MacLeod, says in relation to  
30 the ground rules we talked about in Ottawa, certainly



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1 does not correspond to my understanding. Do I under-  
2 stand from what Mr. MacLeod says now the statements  
3 that will have to be met by people interested in  
4 meeting them consist of the Green Book - I thought  
5 that was all we had to deal with plus certain other  
6 selected material. Mr. MacLeod says in due course he  
7 will be presenting to the Commission. If this is so  
8 may I suggest in order to be helpful to the Commission  
9 from the point of view of the manufacturers' associa-  
10 tion, to deal with it that Mr. MacLeod be urged to  
11 put these additional matters on the record so we may  
12 read the Green Book plus this additional information  
13 and be in a position to answer the entire case. I  
14 use the word "case" in quotations as I realise the  
15 circumstances of this inquiry under Section 42. I  
16 had believed, erroneously, obviously, from Mr. Mac-  
17 Leod's statement, that the pertinent information to  
18 which he attached significance was, to which he was  
19 directing the attention of the Commission, was in  
20 the Green Book, that is the quotations and so on  
21 that were contained throughout the Green Book. I  
22 now understand him to say in addition to anything in  
23 the Green Book there is some additional information  
24 he is going to put before the Commission. My only  
25 comment is to let us know when this is going to be  
26 put forward so we can examine it as well as the  
27 Green Book in the compilation of our submission  
28 which we are working on and which is coming around  
29  
30





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Denholm

1262

1 pretty soon in October.

2 MR. MACLEOD: The material which the  
3 Director relies on is indicated in Chapter 1 of the  
4 statement, all of the material. The Green Book  
5 purports to be a synopsis of the conclusions drawn  
6 by the Director from the material which is examined,  
7 the nature of the material which is examined as indi-  
8 cated in Chapter 1 of the Green Book. The Green Book  
9 will be put before the Commission along with all the  
10 other material mentioned in Chapter 1 in support  
11 thereof.  
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1 Maybe the Director on  
2 occasions has drawn erroneous conclusions. We  
3 studied this material for over a month and in many  
4 instances we have examined material and made broad  
5 general statements. If there is any particular bit  
6 of evidence mentioned in Chapter 1 which any party  
7 appearing feels that it must have to present its  
8 case properly, I will undertake on behalf of the  
9 Director, assuming that the thing does not become  
10 incapable of physically being performed, but if  
11 there is any particular information that any of my  
12 learned friends or there clients want, I will under-  
13 take on behalf of the Director, to make it available  
14 at least for their inspection, and if it is a small  
15 thing I will, of course, supply them with copies of  
16 anything they want. If it is something large, we  
17 will allow them to inspect it and examine it at  
18 their convenience.  
19

20 MR. HUME: That is very nice, and it  
21 is certainly extended in the spirit of co-operation.  
22 My only question is when, if Mr. MacLeod is inten-  
23 ding to place additional information to the Green  
24 Book, perhaps he can indicate when it will be placed,  
25 so that we can have a chance of finding out what  
26 additional quotations or statistics he has. I  
27 presume he is not going to hand you the three filing  
28 cabinets full of material, but some of it.  
29

30 MR. MACLEOD: I fully intend, Mr.



1 Hume, to hand to the Commission the three filing  
2 cabinets with a complete list of the material that  
3 is therein contained.

4 THE CHAIRMAN: I thought that would  
5 be the position, that you would make available to  
6 us all the data on which this volume is based. The  
7 question is, and it may be of some importance, how  
8 an explanation of such material can be offered  
9 unless the parties who desire to make the explanation  
10 know just what the data is.

11 MR. HUME: I understand of course  
12 that the material is available to you, but it is not  
13 going to form part of the transcript. People reading  
14 this are not going to know what material is placed  
15 before this Commission as evidence or material without  
16 knowing, and I am not suggesting that it all not be  
17 placed if it is deemed necessary by the Director,  
18 but I would like to know when and what will be  
19 placed. Many people are examining this Green Book,  
20 and if this work is to be increased, and we know the  
21 material, we will do our best to answer if it needs  
22 to be answered. Just the date.

23 THE CHAIRMAN: And Mr. MacLeod wants  
24 to know what you want.

25 MR. HUME: Everything he is going to  
26 put on the public record. He says Chapter 1. He  
27 has presented the Green Book, which is part of the  
28 record, and now what are these articles and records  
29  
30



1 and so on that he feels necessary to read into the  
2 record to supplement the Green Book?

3 MR. HINKSON: There are two particular  
4 references in the Green Book from which inferences  
5 are drawn, and certainly with respect to those two  
6 matters I wish to direct the witness' attention to  
7 them, and have him give an explanation of them.

8 THE CHAIRMAN: Yes, that is what we  
9 are here for.

10 MR. HINKSON: Yes, but if my friend  
11 avoids doing that here and goes back to Ottawa, I  
12 am in difficulty, because I do not then have an  
13 opportunity to have them commented upon or explained.

14 THE CHAIRMAN: I think he has asked  
15 the questions that he thought were raised out of the  
16 brief which was filed this morning, and you may go  
17 as far as you like with other matters that you think  
18 should be discussed.

19 MR. HINKSON: It all arose because my  
20 friend touched first upon the newspaper articles  
21 and then said he will produce other documents in  
22 Ottawa. I am trying to find out from my learned  
23 friend exactly what other documents he will produce.

24 THE CHAIRMAN: I think it is clear  
25 that Mr. MacLeod intends to lay before the Commission  
26 all the material out of which this document has been  
27 prepared. That he says is three filing cabinets,  
28 much of which may not even be of relevance to the  
29  
30



1 particular issues.

2 MR. HINKSON: I think along those  
3 lines perhaps some of the documents he has taken,  
4 for example, from the Pharmaceutical Association of  
5 British Columbia, while he desired to examine them,  
6 really don't form any foundation for a statement  
7 made in the Green Book, but what I was wishing to  
8 find out is which ones he attached significance to  
9 and which ones he considered not to be relevant.

10 THE CHAIRMAN: I am not sure if Mr.  
11 MacLeod can assist you sir with that problem. We  
12 do desire that wherever there are matters or conclu-  
13 sions set out in this book, that any person or orga-  
14 nization to which these conclusions refer, should  
15 have a full opportunity of explanation.

16 MR. HINKSON: I appreciate that, and  
17 that was our intent in presenting the statement to  
18 you this morning.

19 THE CHAIRMAN: I don't know what  
20 further we can do at the moment. If Mr. MacLeod is  
21 in a position to indicate the particular documents  
22 he has in mind, maybe it would facilitate your  
23 questioning of the witness when Mr. MacLeod has  
24 concluded his examination.

25 MR. MACLEOD: No, I don't think there  
26 is anything I can usefully say. I have been going  
27 through, it is around pages 16 and 17 part of it  
28 appears, and perhaps 15, where in a paragraph or two



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1 what the Director has been able to learn about the  
2 attitude of the certain parties in the drug industry  
3 towards generic drugs, and comments that have been  
4 made about the superiority of brand name products,  
5 and so on, is summarized very shortly. Obviously,  
6 that summary is extremely brief, because it meant  
7 reading trade journals, reading the documents from  
8 these two association offices we visited, and it  
9 meant a month of work, and that is all summarized in  
10 just a paragraph or two.

11  
12 I think, sir, I can just refer back  
13 to Chapter 1, and say we have stated there the  
14 material that this Green Book is based on, and we  
15 propose to put that material before the Commission  
16 in support of the Green Book, and we will make  
17 available to anybody who wants it any particular  
18 document in our possession, subject of course to  
19 this, that if it relates to the confidential affairs  
20 of any company we will not make it available to any  
21 other company.

22 THE CHAIRMAN: That is about as far as  
23 we can get.

24 MR. HUME: Unless Mr. MacLeod has in  
25 mind the volume numbers of the various trade journals,  
26 this is paragraph 11. He talks about various things  
27 he is going to ask the Commission to consider, but  
28 if he could tell us what they are, then it would  
29 give to people working on this thing an opportunity  
30





1 of reading those journals. He just says various  
2 trade journals. He does not indicate what they are.  
3 He must know the various trade journals he is going  
4 to lay before you, and perhaps read into the record,  
5 or attach as exhibits. If he does know, it would be  
6 helpful if he could tell me when he will give that  
7 information.

8  
9 MR. MACLEOD: The trade journals are  
10 Drug Merchandising, published by Maclean-Hunter;  
11 Canadian Pharmaceutical Journal, published by the  
12 Canadian Pharmaceutical Association; and the Western  
13 Drugs. I am not sure by whom it is published.

14 MR. HINKSON: I believe it is the  
15 Journal of Commerce.

16 MR. MACLEOD: For instance, in the  
17 Canadian Pharmaceutical Journal, practically every  
18 month there is a list of new pharmaceuticals reaching  
19 the market. It is the submission of the Director  
20 that the Commission may examine the volumes of the  
21 Canadian Pharmaceutical Journal for a year, and it  
22 will have a fair idea of the new pharmaceuticals  
23 that are introduced to the drug trade in Canada,  
24 and similarly, by examining these various journals,  
25 it can form a fairly accurate idea of the nature  
26 of the advertising done by the manufacturers to the  
27 retailers, but to specifically answer my friend's  
28 question, it is the three journals that I have  
29 named, and we propose to supply the Commission with  
30





1 copies of those journals covering the last several  
2 years.

3 THE CHAIRMAN: We don't need copies  
4 of all the issues for several years?

5 MR. MACLEOD: Yes sir.

6 THE CHAIRMAN: That is more reading  
7 than we had hoped for.

8 MR. MACLEOD: Well, they will be  
9 there for the Commission's use if they desire.

10 MR. HUME: Is several two, three, or  
11 five, or six?

12 MR. MACLEOD: I would say three years.

13 MR. HUME: That is very helpful,  
14 thank you.

15 MR. MACLEOD: Mr. Denholm, I just  
16 want to put a series of propositions you might call  
17 it, or draw your attention to various aspects of the  
18 trade, and ask for your comments. First of all,  
19 we have had, not in your province I don't think, but  
20 in the briefs of pharmaceutical associations from  
21 other provinces we have had stress on the long hours  
22 that the druggist works, the pharmaceutical chemist.  
23 In your opinion is that condition true of British  
24 Columbia?

25 MR. DENHOLM: The question of the  
26 long hours the pharmacist works, or the long hours  
27 the pharmacies are open. They are not necessarily  
28 the same things.

29 MR. MACLEOD: It was stressed on  
30 several occasions that the pharmacist works twelve  
31 to fourteen hours a day, particularly the pharma-  
32 cist-owner, and that he is a devoted servant of the



1 community in that sense. We have the phenomena in  
2 other provinces of one-man drugstores, where the  
3 proprietor is the only man and does not have employees.

4 MR. DENHOLM: In the metropolitan  
5 areas in British Columbia, and in those pharmacies  
6 which are operated on a one-man basis, it would  
7 appear a proper statement, yes.

8 MR. MACLEOD: You find pharmacists  
9 working long hours?

10 MR. DENHOLM: Yes sir.

11 MR. MACLEOD: I was just wondering.  
12 There seems to me to be a little conflict there  
13 between the problem which you have touched on and  
14 dealt with, I thought very fully in your brief,  
15 about the pharmacist keeping up with current infor-  
16 mation and advising the doctor. How can a busy man,  
17 who is twelve to fourteen hours on the job find  
18 time for outside reading sufficient to keep up with  
19 the multiplicity of new drugs?

20 MR. DENHOLM: As the length of time  
21 that he works or is on duty in his pharmacy lengthens,  
22 certainly the opportunities for such perusal of  
23 current literature and so on would be more difficult.

24 MR. MACLEOD: Is keeping up with new  
25 drugs a problem for the druggist, and perhaps you  
26 can speak of this, having been a practising pharma-  
27 cist yourself?

28 MR. DENHOLM: In what respect sir?  
29  
30



1 MR. MACLEOD: Just keeping fully  
2 informed of the new drugs that come out?

3 MR. DENHOLM: Yes, it is indeed sir.  
4 This requires time to keep abreast of the develop-  
5 ments.

6 MR. MACLEOD: Do you know if the  
7 pharmacist receives the same promotional and explana-  
8 tory material as the doctor with reference to new  
9 drugs?

10 MR. DENHOLM: I don't think I could  
11 answer that question sir, because I am not altogether  
12 familiar with the type of material or the material  
13 itself received by physicians.

14 MR. MACLEOD: What sources of informa-  
15 tion does the pharmacist have?

16 MR. DENHOLM: He has the journals of  
17 course. You referred to the Canadian Pharmaceutical  
18 Journal, and you are probably aware that in each  
19 Canadian Pharmaceutical Journal there is a section  
20 devoted to new products produced by Dean Hughes of  
21 the Faculty of Pharmacy at the University of Toronto.  
22 There are also articles on new drugs appearing  
23 periodically in the other publications that you  
24 mentioned. He also receives some information on  
25 new products from the manufacturers direct, either  
26 through mailing or more particularly through the  
27 visits of representatives of the companies, and more  
28 recently he has the opportunity for studying new  
29  
30



Denholm

1272

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1 drugs through the publication of the Compendium of  
2 Pharmaceutical Specialties, by the Canadian Pharma-  
3 ceutical Association.  
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1 MR. MACLEOD: Yes. That is this  
2 volume here, is it, by Dean Hughes?

3 MR. DENHOLM: Yes.

4 MR. MACLEOD: That, of course, would  
5 not contain very elaborate information about any  
6 drug, would it?

7 MR. DENHOLM: It is not elaborate,  
8 sir, no. It is not elaborate. There is no clinical  
9 information, if that is your point, sir.

10 MR. MACLEOD: Is it true that pharma-  
11 cists depend largely on the manufacturer for the  
12 first few months, at least, after a new drug is intro-  
13 duced?

14 MR. HINKSON: Depends for what.

15 MR. MACLEOD: For information.

16 MR. DENHOLM: Well, I would have to  
17 enter into the boundary of supposition if I was to  
18 answer that question.

19 MR. MACLEOD: You have been a practi-  
20 sing pharmacist yourself?

21 MR. DENHOLM: Yes.

22 MR. MACLEOD: What did you find?

23 MR. DENHOLM: Generally speaking,  
24 the appearance of information in the journals and  
25 in such publications as that and various other  
26 types of information, to which many pharmacists  
27 subscribe, is later coming out than the initial  
28 information dispatched by the manufacturers.  
29  
30



1 MR. MACLEOD: So that in the case of  
2 a new drug there would be a period of some length  
3 at least where the pharmacist would rely on the  
4 information furnished him by the manufacturer?  
5

6 MR. DENHOLM: I don't think it would  
7 be true to say he would rely on it. It is the only  
8 information available to him during that usually  
9 brief period of time.

10 MR. MACLEOD: If he were asked by a  
11 physician during that period about advice on a cer-  
12 tain drug, this is the only information he would have  
13 available?

14 MR. DENHOLM: He would have available,  
15 that is correct, sir.

16 MR. MACLEOD: How long does it take  
17 for a new drug to get in such official publications  
18 as the British Pharmacopoeia or the Pharmacopoeia of  
19 the United States?  
20

21 MR. DENHOLM: I really couldn't say,  
22 sir.

23 MR. MACLEOD: You have no knowledge  
24 of that?

25 MR. DENHOLM: No.

26 MR. MACLEOD: I have asked several  
27 others about this and I will just, for the record,  
28 ask you if your attention has been drawn to the  
29 article in the Canadian Pharmaceutical Journal,  
30 February 1961 suggesting that retail pharmacists do





1 not deserve professional status. Have you read that  
2 or did you read it at the time it came out?

3 MR. DENHOLM: I read it at the time  
4 it came out, yes.

5 MR. MACLEOD: What is your opinion  
6 of the matter?

7 MR. DENHOLM: My opinion of the matter  
8 is that pharmacists do indeed deserve professional  
9 status and I think this was lengthily outlined to  
10 the Commission in our brief this morning.

11 MR. MACLEOD: Are you in a position to  
12 give any estimate of the percentage of sales which  
13 would be accounted for by prescriptions in drugstores  
14 in British Columbia?

15 MR. DENHOLM: Any figures that I  
16 could give you purporting to show the percentage of  
17 prescription sales as related to total sales would  
18 be those figures from the Canadian Pharmaceutical  
19 Association Annual Survey conducted by Professor  
20 Fuller. I note from the Green Book those figures  
21 are already in your possession.

22 MR. MACLEOD: It is something between  
23 20 and 30% as an average figure, according to Profes-  
24 sor Fuller, is it not?

25 MR. DENHOLM: Is it?

26 MR. MACLEOD: I want to ask you your  
27 opinion on this: of the prescriptions that are  
28 dispensed, only a small proportion are actually  
29  
30



1 compounded by the pharmacists themselves. Is that  
2 not so?

3 MR. DENHOLM: This is largely true,  
4 yes. This was commented on in the Green Book and  
5 again in our brief this morning.

6 MR. MACLEOD: Well, do you think  
7 there is an economic waste there in having every  
8 single drugstore equipped with a dispensary and  
9 the stock and equipment and so on that goes with  
10 it? Is it not something the same as - and I think  
11 I used this illustration before - requiring every  
12 gas station to have a qualified mechanic on duty  
13 at all times? Could not the actual dispensing be  
14 handled by a much smaller number of units in dispen-  
15 sary areas with an overall saving?

16 MR. DENHOLM: I don't know that I  
17 would care to g~~ue~~stimate, as you are inviting me to  
18 do, on the economics which could be effected in  
19 the way you have described.

20 THE CHAIRMAN: We don't want any  
21 g~~ue~~stimate.

22 MR. DENHOLM: I think Mr. MacLeod  
23 was inviting me to do that, sir.

24 THE CHAIRMAN: I think he was inviting  
25 you to give any information of which you are in  
26 possession, if you are in p~~o~~ssession of any forma-  
27 tive opinion that might be useful.

28 MR. MACLEOD: Is there a problem in  
29  
30



1 keeping the elder druggists informed as to the new  
2 drugs which have come onto the market; drugs which  
3 were not even heard of when they studied pharmacy?

4 MR. DENHOLM: Not only the elder  
5 pharmacists; all pharmacists, and this is a matter  
6 which keeps the attention of another committee  
7 which has not been mentioned here today of our  
8 Association, the Education Committee.

9 By way of example, last year the  
10 Education Committee established and ran a one night  
11 a week, fifteen-week refresher course on new drugs.  
12 These lectures took place at the University of  
13 British Columbia under the joint auspices of the  
14 Faculty of Pharmacy and the Education Committee of  
15 the Association.

16 The Education Committee also last  
17 year sponsored, again in conjunction with the Faculty  
18 and extension department of the University, a two-  
19 day refresher course for pharmacists on a wide  
20 range of topics having to do with developments in  
21 pharmacy.

22 In addition to those two local endeavours,  
23 a capsule College Committee of the Association arranges  
24 panels of speakers who go about to the various areas  
25 of the Province and speak to pharmacists there on  
26 new drugs and developments in pharmaceutical prac-  
27 tices.

28 This Spring, for example, such capsule  
29  
30



1 college toured and made addresses to the pharmacists  
2 in Kamloops, Penticton, Cranbrook and Nelson.

3 Yes sir, in direct answer to your  
4 question the problem of keeping and assisting our  
5 members to keep up with drug developments is a very  
6 prevalent one to us. We are attempting to deal with  
7 it in the ways which I have described.

8 MR. MACLEOD: I want to draw your  
9 attention to something. I do not read this in criti-  
10 cism of the druggists in any way whatsoever but I do  
11 suggest that raised the point that they are extremely  
12 busy men who find it difficult to attend such  
13 refresher courses. I note in the Western Druggist  
14 in June 1961 this paragraph appears:

15 "Because of poor attendance in the  
16 last capsule college refresher course, the committee  
17 has decided to recommend in its annual report that  
18 the capsule college in Vancouver be discontinued".

19 I just show you the article.

20 MR. DENHOLM: Yes, I am quite familiar  
21 with it, sir, yes.

22 There is a perfectly good reason for  
23 this. It all ties in with what I have just been  
24 telling the Commission.

25 Until this year and including this  
26 year, in fact, the capsule college programme that  
27 was described was undertaken not only in the small  
28 centres throughout the Province and Victoria and so  
29  
30



1 on, but also in Vancouver.

2 The response to this capsule college  
3 programme in Vancouver has not been good certainly  
4 by comparison with the up-country points. The  
5 Committee, in urging this conclusion, felt that the  
6 reason probably was that the Vancouver pharmacists  
7 are the ones that are being offered these other  
8 refresher course services, the 15-week course and  
9 the two-day course.  
10

11 By and large, the majority of members  
12 attending those two courses are local Vancouver, or  
13 mainland at least, pharmacists so it was determined  
2 14 the capsule college was somewhat superfluous for  
15 this particular area. I believe that this is the  
16 Committee's thinking in this regard, sir.

17 MR. MACLEOD: Do you know if in the  
18 British Columbia area the suggested code for the  
19 marketing price charged for a prescription, the code  
20 suggested by the Canadian Pharmaceutical Association,  
21 is used?  
22

23 MR. DENHOLM: I am familiar with the  
24 code but I have no way of knowing to what extent it  
25 is used, sir.

26 MR. MACLEOD: Did you, when you were  
27 practising pharmacy, use it?

28 MR. DENHOLM: In issuing a copy of a  
29 prescription.

30 MR. MACLEOD: If you have used it,





1 perhaps you will tell me how you did it and just  
2 under what circumstances.

3 MR. DENHOLM: This is the recommended  
4 code to be used when the patients request a copy of  
5 a prescription and the Pharmacy Act provides that  
6 if a patient requests a copy of a prescription, it  
7 must be given and this is quite frequently done.

8 It is suggested that the code should  
9 be used when such copy is handed out.

10 I would say again, sir, I cannot  
11 comment on how widely this is used.

12 Now, when I was in the retail practice,  
13 during the six years I was in practice I worked for  
14 two different pharmacists. In one it was used, in  
15 the other it was not. This is a matter of individual  
16 choice, sir.

17 MR. MACLEOD: Were those pharmacies  
18 located in the City of Vancouver?

19 MR. DENHOLM: Yes.

20 MR. MACLEOD: Both of them?

21 MR. DENHOLM: Yes.

22 MR. MACLEOD: Are there a number of  
23 professional drugstores in Vancouver?

24 MR. DENHOLM: All pharmacies are  
25 professional, sir.

26 MR. MACLEOD: I am using the term  
27 "professional" in a specialized sense, as it appears  
28 to be commonly used in the journals.  
29  
30





1 MR. DENHOLM: What was the question  
2 again?

3 MR. MACLEOD: Are there a number of  
4 these stores in Vancouver?

5 MR. DENHOLM: Quite a number, sir,  
6 yes.

7 THE CHAIRMAN: That is rather interes-  
8 ting. I was wondering if you would give us how many.  
9 In most places we have heard about there being many.  
10 There is one opposite the Vancouver Hotel.

11 MR. DENHOLM: Yes. I don't know if I  
12 could estimate offhand. There are quite a number of  
13 smaller ones in the suburban areas where there are  
14 medical centres and where they are close to possibly  
15 a volume of prescriptions.

16 Any figure I could give you, sir,  
17 would be a sheer guess. I could ascertain the figure  
18 for you in the future from our records.

19 THE CHAIRMAN: I think it would be  
20 interesting to see the proportion of the total phar-  
21 macists engaged exclusively in prescription activi-  
22 ties.

23 MR. DENHOLM: I would be pleased to  
24 supply it, sir.

25 MR. MACLEOD: Are you familiar with  
26 this book, the price book of the Canadian Pharmaceu-  
27 tical Journal? The one I am showing you is the 21st  
28 edition of November 1960.  
29  
30



1

MR. DENHOLM: Yes sir.

2

3

MR. MACLEOD: When you were a practising pharmacist did you use that book?

4

5

MR. DENHOLM: No I did not.

6

7

MR. MACLEOD: Did the drugstore in which you were employed use the book or have a copy of it?

8

9

MR. DENHOLM: No, they did not, sir.

10

11

MR. MACLEOD: Is the information contained in this book largely a duplicate of the Druggists' Bulletin Service?

12

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MR. DENHOLM: I don't know if I can comment on that, sir. I am not too familiar with the actual makeup of this book although I am familiar with the sight of it and the fact it exists because of my activities in the Canadian Pharmaceutical Association. I am not familiar enough with the book itself to compare it to Druggists' Bulletin Service. I understand it to be a catalogue, as it were, or a list of list prices.

23

24

MR. MACLEOD: Isn't the Druggists' Bulletin Service essentially the same thing?

25

26

27

28

MR. DENHOLM: Basically.

MR. MACLEOD: Do you have any knowledge of how widely this book is used in the British Columbia area?

29

30

MR. DENHOLM: I have no idea at all, sir.



1 MR. MACLEOD: You cannot say anything  
2 about that?  
3

4 MR. DENHOLM: No.

5 MR. MACLEOD: Do you consider or does  
6 the Association consider it unethical to have a  
7 doctor to suggest to a patient that a patient have  
8 this prescription filled at a particular drugstore  
9 because that drugstore is selling more cheaply?

10 MR. DENHOLM: Well, sir, it is not  
11 the function nor the position of the Association of  
12 Pharmacists to comment on the ethics of physicians.  
13 This is a function which is undertaken by the College  
14 of Physicians and Surgeons and I believe that in fact  
15 one section of their Act specifies that referral to  
16 a specific drugstore or the use of prescriptions  
17 with a drugstore name on it constitutes unethical  
18 conduct, but that is not a matter for decision by  
19 the pharmacists.  
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MR. MACLEOD: Do you know if in British Columbia the practice of doctors prescribing with the name of the drugstore on top?

MR. DENHOLM: On one or two occasions such a practice has been drawn to our attention.

MR. MACLEOD: What have you done about it?

MR. DENHOLM: We have indicated to the pharmacist involved that it is our understanding of the Medical Act that the use of such prescription by a physician constitutes an unethical practice as far as they are concerned and drawing it to their attention.

MR. MACLEOD: Have you also drawn to the attention of the Medical Association the fact a doctor or certain doctors were recommending their patients get prescriptions filled at certain drugstores because prices at those drugstores were cheaper?

MR. DENHOLM: Would you repeat the question please, sir?

MR. MACLEOD: It is rather long. Perhaps the reporter would read it back.

--- (Have you also drawn to the attention of the Medical Association the fact a doctor or certain doctors were recommending their patients get prescriptions filled at certain drugstores



1 because prices at those drugstores were cheaper?

2  
3 MR. DENHOLM: With the exclusion of  
4 because prices at those drugstores were cheaper,  
5 yes sir. We have on occasion when it has been  
6 reported to us and on what we believed to be substan-  
7 tial grounds that such a recommendation has been made  
8 when a physician has recommended to a patient that he  
9 go to a specific drugstore for whatever reason. The  
10 reason is of little interest to us. We have raised  
11 the matter with the proper medical authority because  
12 it is not our province to comment to the physician on  
13 these matters.

14 MR. MACLEOD: I suggest to you it was  
15 done in one particular case, at least, because the  
16 physician was telling the patient that he could  
17 obtain the drug cheaper at a specific drugstore.

18 MR. DENHOLM: As I say, Mr. MacLeod,  
19 regardless of the reason the physician told the  
20 patient we have made a statement on occasion to the  
21 College of Physicians and Surgeons without reference  
22 to the reason. The reason had nothing to do with  
23 the fact which we were referring to the College.

24 MR. MACLEOD: I see.

25 MR. HINKSON: Would it not assist if  
26 my friend would indicate the particular occasion he  
27 is suggesting such an occurrence had specifically  
28 occurred? If we get at the facts here perhaps they  
29 would assist us.  
30



1 MR. MACLEOD: I can't indicate the  
2 specific occasion. I am asking the witness whether  
3 it was done. He said it was done. He has told us  
4 the reason it was done. I have no documents.

5  
6 THE CHAIRMAN: As long as you are both  
7 talking about the same thing it is all right.

8 MR. MACLEOD: I have no documents  
9 that say it was done. I simply asked the witness  
10 if it was done. He said, yes. He has explained very  
11 clearly the reason why it was done.

12 THE CHAIRMAN: If it is the same  
13 instance.

14 MR. HINKSON: That is the problem when  
15 my friend is asking this type of question without  
16 specific facts.

17 THE CHAIRMAN: It makes it difficult.  
18 The witness has given a statement that there may have  
19 been some representations made when a doctor was  
20 recommending to patients that he get prescriptions  
21 filled by certain drugstores whatever reason the  
22 doctor may have given and whether he gave...

23 MR. DENHOLM: Wasn't a matter of  
24 consideration.

25  
26 THE CHAIRMAN: As I understand the  
27 witness he said the Association had sometimes drawn  
28 it to their attention.

29 MR. HINKSON: I appreciate the same  
30 difficulty you mentioned. We want to make certain





1 we are speaking about the same occasion.

2 THE CHAIRMAN: He has indicated what  
3 the practice is. He means that is what the practice  
4 is.  
5

6 MR. HINKSON: Yes.

7 MR. MACLEOD: What is the going wage  
8 of a pharmacist in this area, do you know, starting?

9 MR. DENHOLM: I am afraid I couldn't  
10 say, sir. We keep no statistics of wages. We pay  
11 no - we have no system of calculating it. The only  
12 interest which we have in this field is in connection  
13 with work we do in educational colleges when speaking  
14 to high school students and so on and telling them  
15 about the profession of pharmacy. We have from time  
16 to time gathered some information in this field, but  
17 I couldn't answer specifically.

18 MR. MACLEOD: Do you ever tell these  
19 groups you are speaking to what they may expect in  
20 the way of salary if they enter the profession?  
21

22 MR. DENHOLM: We give them ranges.

23 MR. MACLEOD: Would you give us the  
24 ranges you give these groups?

25 MR. DENHOLM: The last figure we had  
26 the starting salary ranged between \$100 and \$125 a  
27 week.

28 MR. MACLEOD: I suppose you would be  
29 in no position to say at what salary a proprietor  
30 of a drugstore would hire a clerk for non-dispensing



1  
2 duties?

3 MR. DENHOLM: A lay clerk?

4 MR. MACLEOD: Yes.

5 MR. DENHOLM: No sir, not at all.

6 MR. MACLEOD: Do you recall the discount  
7 which manufacturers normally allow retailers being  
8 raised from 35% to 40%?

9 MR. DENHOLM: No sir, at the time at  
10 which I went into practice in 1951, you will recall  
11 the discount from most manufacturers at that time was  
12 40%.

13 MR. MACLEOD: 40%, I see. Anything  
14 that may have occurred along those lines was  
15 certainly before you entered the profession.

16 MR. DENHOLM: That is correct, sir.

17 MR. MACLEOD: How long - I have just  
18 forgotten this, I know you mentioned it - how long  
19 since you have been actively practising pharmacy?

20 MR. DENHOLM: October 1st, 1957.

21 MR. MACLEOD: October '57, about four  
22 years. Can you express any opinion from your  
23 experience as a pharmacist yourself on the effect  
24 of promotional campaigns launched by manufacturers?  
25 Were you in practice when tetracycline came on the  
26 market?

27 MR. DENHOLM: Yes.

28 MR. MACLEOD: Taking that as an example  
29 did you note any relationship between professional  
30



1 efforts exerted by the manufacturers and the sale of  
2 the drug in the drugstore of which you were connected?

3 MR. DENHOLM: Hardly, sir. The promo-  
4 tional efforts as you call them were, of course,  
5 directed to the physician, the prescriber. I have  
6 no knowledge of the promotional efforts that were  
7 undertaken.  
8

9 MR. MACLEOD: Just one moment, isn't  
10 it true that when a campaign is launched to the  
11 physician the detail man comes around to the drug-  
12 stores and says we are, in fact, launching a campaign  
13 for this drug directed to the physician?

14 MR. DENHOLM: That is often the case.  
15 May I finish the answer?

16 MR. MACLEOD: Yes, surely. I am sorry  
17 I interrupted you.

18 MR. DENHOLM: I have no knowledge of  
19 the actual campaign done on drug 'X', tetracycline,  
20 if you wish. Certainly when a new drug comes on  
21 the market the pharmacist is usually advised by the  
22 company's representative. He is also advised that  
23 physicians have been detailed on it or they have  
24 received information on it and certainly in some  
25 cases this promotion appears to be effective and  
26 this effect is noted in an increase or an immediate  
27 rush of prescriptions for this particular item.  
28 In other cases there is no effect, which would  
29 indicate little or no effect - which would indicate  
30



1  
2 the promotion wasn't successful. You ask me to  
3 relate this development in the pharmacy to the actual  
4 promotion that was done. I can't do that because I  
5 am not familiar with the actual promotion done, only  
6 it was being done.

7 MR. MACLEOD: It would seem to me the  
8 druggist would be in a position to judge if he is  
9 told the doctors are being detailed on a drug at  
10 this particular time - he is the man who sells the  
11 drug and you should be able to express some opinion,  
12 I would think, as a pharmacist, on what effect these  
13 promotional campaigns have.

14 MR. DENHOLM: I am sorry if I didn't  
15 make myself clear. I thought I had already expressed  
16 it. I shall repeat it, sir. In some cases the  
17 effect was very marked and in other cases the effect  
18 was negligible viewed from the result of the number  
19 of prescriptions dispensed during the time. One  
20 could only conclude one particular programme, what-  
21 ever it was, was successful and one wasn't successful.  
22  
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1 THE CHAIRMAN: You state you would not  
2 know anything about the actual campaign. Would you  
3 know enough about it from the detail men or other-  
4 wise to say that it might be called a massive  
5 campaign in one instance, and a relatively small  
6 campaign in another, or would that be completely  
7 outside your knowledge?  
8

9 MR. DENHOLM: I am afraid I couldn't  
10 comment on that sir, because the terms massive and  
11 minimum are highly relative, and I am not in a posi-  
12 tion to judge this relationship, nor have I ever been.

13 THE CHAIRMAN: That is what I wanted  
14 to know, because there might be a campaign on which  
15 the company spent a great deal of money for repeated  
16 publicity, and another case where they only went  
17 around once and didn't spend a great deal of either  
18 time or money, and the results might depend partly  
19 on that.

20 MR. DENHOLM: I should think that the  
21 only person who could evaluate that would be the  
22 recipient of the campaign. Certainly the pharmacist  
23 is not in a position to know what is going on when  
24 it is not directed to him.

25 MR. MACLEOD: But the pharmacist  
26 would be in a position to gauge the effect on a  
27 number of doctors. Certainly you would have pres-  
28 criptions from various doctors coming to your drug-  
29 store?  
30

MR. DENHOLM: Yes.





1  
2 MR. MACLEOD: And couldn't you,  
3 because of that very fact, knowing that a campaign  
4 was on and receiving the prescriptions written by a  
5 number of doctors, be in some position to gauge the  
6 effect of the campaign?

7 MR. DENHOLM: Oh, the effect of  
8 course. I thought I implied that the pharmacist  
9 could tell the effects of the campaign, but he  
10 couldn't relate that effect to the composition of  
11 what the campaign does.

12 MR. MACLEOD: Is it your opinion,  
13 based on your experience along the lines we have  
14 been discussing, that the promotional efforts of the  
15 manufacturers pay off, and that they do induce the  
16 doctors to prescribe the drugs that are being promo-  
17 ted?

18 MR. DENHOLM: Well, I would say sir  
19 that certainly on the receiving end of the prescrip-  
20 tions it would be indicated that something was  
21 paying off, and directing the physician's attention  
22 and encouraging his acceptance of such-and-such a  
23 product in one case, and in another case something  
24 was not paying off. Presumably if a new product  
25 comes on the market and the pharmacist suddenly  
26 receives a lot of prescriptions for it, as you say  
27 there must have been a successful campaign. This  
28 is not to say that this was necessarily due to the  
29 Chairman's word massive, but thorough. The  
30





1 pharmacist is not in a position to gauge this,  
2 because he does not know the composition of the  
3 campaign. He only sees the results.

4 MR. MACLEOD: Does not the detail  
5 man explain to you what is being done in the way of  
6 promotion to doctors?

7 MR. DENHOLM: Not in detail, sir,  
8 very rarely.

9 MR. MACLEOD: So the best you can do  
10 is to say that in some cases it is successful and  
11 in some cases it is not?

12 MR. DENHOLM: Quite so.

13 MR. MACLEOD: Are you able to form  
14 any opinion as to whether or not these promotional  
15 efforts may be wasteful?

16 MR. DENHOLM: I would have no know-  
17 ledge of that sir.

18 MR. MACLEOD: Not being connected  
19 with the retail drug trade at the moment, I suppose  
20 you cannot express any opinion on the extent of  
21 price cutting in the drug field in the city, can  
22 you?

23 MR. DENHOLM: No sir, I couldn't.

24 MR. MACLEOD: Is there a separate  
25 provincial association in British Columbia besides  
26 what might be called the official association, that  
27 is of retail druggists?

28 MR. DENHOLM: No sir, we are the only  
29  
30



1 provincial pharmaceutical association in British  
2 Columbia.

3  
4 MR. MACLEOD: To your knowledge are  
5 there local associations?

6 MR. DENHOLM: Yes there are.

7 MR. MACLEOD: Are these fairly common  
8 throughout the Province?

9 MR. DENHOLM: They are relatively few  
10 sir.

11 THE CHAIRMAN: Do you mean by that  
12 that there are a number of substantial areas in the  
13 Province where there is no local association?

14 MR. DENHOLM: That is so sir.

15 MR. MACLEOD: Is there an association  
16 in the Greater Vancouver area?

17 MR. DENHOLM: Yes.

18 MR. MACLEOD: And in the Victoria area?

19 MR. DENHOLM: Yes.

20 MR. MACLEOD: Nanaimo?

21 MR. DENHOLM: Not an official associa-  
22 tion sir, no.

23  
24 MR. MACLEOD: You mentioned the  
25 journals as being a source of information to the  
26 druggist. Are not the journals in fact largely  
27 slanted towards the commercial or economic aspects  
28 of the druggist's operations?

29 MR. DENHOLM: I think if you recall  
30 correctly, Mr. Chairman, I referred primarily to



1 the Canadian Pharmaceutical Association Journal,  
2 which has in each issue a specific section of new  
3 products, and in its scientific section, which is  
4 largely at the back of the book, also contains a  
5 specific article each month on some particular  
6 aspect of pharmaceuticals, or something of this nature.  
7 The other journals which you have there sir are  
8 largely trade journals, yes.

10 MR. MACLEOD: Although perhaps in  
11 fairness to Drug Merchandising, it might be pointed  
12 out that I think they do list new drugs too.

13 MR. DENHOLM: They do list new pro-  
14 ducts sir, yes.

15 MR. MACLEOD: I think those are all the  
16 questions I have Mr. Chairman.

17 MR. HINKSON: Mr. Denholm. Some  
18 reference has been made to the distinction between  
19 generic and brand name drugs. Perhaps it would  
20 assist the Commission if you could comment generally  
21 on how many of the 26,000-odd brand name drugs in  
22 different dosage forms referred to in the Green  
23 Book, how many of those are produced in generic form?

24 MR. DENHOLM: Well, all drugs are  
25 produced with the generic name. Some also have a  
26 brand name. If you mean, sir, how many are sold by  
27 the generic name only, very few indeed. They are by  
28 and large the large volume of drug items, the items  
29 that are moving in volume.  
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THE CHAIRMAN: Just to get the record clear again. There is always some little argument between brand name and trade name. Brand name has sometimes been spoken of as attaching to the manufacturer, and the trade name would be the name of the particular product. Giving the name of the product rather than the name of the company attaching to the company as its brand, the name of the company?

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1  
2 MR. DENHOLM: It is not necessarily  
3 the name of the company but it does identify the  
4 company by virtue of the fact that it is that  
5 company's chosen name.

6 THE CHAIRMAN: The company may make a  
7 variety of products ---.

8 MR. DENHOLM: A brand name.

9 THE CHAIRMAN: Each with a separate  
10 what you are calling brand name and which we have  
11 referred to as trade name. I wanted to be sure we  
12 were referring to the same thing.

13 MR. DENHOLM: Yes.

14 MR. HINKSON: Can you indicate to the  
15 Commission which of the products are generally pro-  
16 duced by the so-called generic manufacturers? I  
17 think throughout the course of the Green Book there  
18 has been some distinction between the so-called  
19 ethical manufacturers and the generic manufacturers.

20  
21 In that context, Mr. Denholm, which  
22 are the drugs that are produced generally by the  
23 generic manufacturers?

24 MR. DENHOLM: Our information certainly  
25 indicates that manufacturers who distribute their  
26 products by the generic name only limit a lot of  
27 their products to products which are in volume  
28 demand. Does that answer your question?

29 MR. HINKSON: Yes. Mr. Chairman, it  
30 has been suggested at times that it would be



1  
2 desirable from the public's point of view if when a  
3 drug is prescribed by a physician it could be bought  
4 in the generic form and I would say --

5 THE CHAIRMAN: Bought under the gene-  
6 ric name without any trade name.

7 MR. HINKSON: Yes. In reading the  
8 transcript of the proceedings that are available to  
9 us up to date I do not believe this point has been  
10 touched upon.

11 I was wondering if you could assist  
12 the Commission as to what proportion of drugs pres-  
13 cribed by physicians could be bought by the generic  
14 name as distinct from the brand name or trade name.  
15 You have said very few, I believe.

16 MR. DENHOLM: A very small percentage  
17 indeed. Again sir, I would be guessing if I were to  
18 say 5%. I think this would be a close estimate, sir.

19 MR. WHITELEY: I wonder if that  
20 answer relates to the question. Does your answer  
21 mean doctors prescribe only 5% by generic name?

22 MR. DENHOLM: No, that was not the way  
23 I understood the question. As I understood the ques-  
24 tion it was of the 23,000 drugs, according to the  
25 Green Book, on the market bought, how many are  
26 distributed by generic name only as well as possibly  
27 --  
28

29 MR. WHITELEY: I think your counsel  
30 asked how many could be bought by generic name.





1 MR. HINKSON: Yes.

2 MR. DENHOLM: The same thing, sir.

3 MR. WHITELEY: Do you mean to say a  
4 trade name can not be bought by generic prescription?  
5

6 MR. DENHOLM: Yes.

7 MR. HINKSON: I think the point is,  
8 sir, there are a limited number that can be bought  
9 in generic form that is of the drugs that the physi-  
10 cian may wish to prescribe are not available on a  
11 generic basis. He cannot prescribe in a great many  
12 cases on a generic basis. They are not available in  
13 that way.

14 MR. WHITELEY: I asked the witness  
15 whether prescriptions written in the generic name  
16 could not be filled by the trade name.

17 MR. HINKSON: Yes, it could, sir.

18 MR. WHITELEY: Therefore it could be  
19 bought.  
20

21 MR. HINKSON: Yes, by a trade name or  
22 brand name, not necessarily --

23 MR. WHITELEY: By generic prescrip-  
24 tion. There is nothing to prevent the filling of a  
25 prescription written in the generic name by any  
26 product of a brand name.

27 MR. HINKSON: I think the problem is,  
28 as I see it, this, sir: that from the various state-  
29 ments made to the Commission up to date, it appears  
30 to me, at least, that a lot of people are under the



1  
2 misapprehension that doctors can prescribe any drug  
3 on a generic basis or perhaps they ought to prescribe  
4 for a drug by the generic name as distinct from a  
5 trade or brand name. The point that I was seeking  
6 to get from the witness was this: not all the drugs  
7 the physician may wish to prescribe are available by  
8 prescribing by the generic brand basis.

9 MR. WHITELEY: I think there is some  
10 confusion. To get away from drugs. You can take  
11 sugar. If you are in Eastern Canada you can get  
12 three or four different brand names of sugar.

13 MR. HINKSON: Yes.

14 MR. WHITELEY: They are all the same  
15 essential chemical.

16 MR. HINKSON: Yes.

17 MR. WHITELEY: There is nothing to  
18 prevent any person, I am not referring to a particular  
19 quality, to get it according to that chemical descrip-  
20 tion. It may be filled by any one of several manufac-  
21 turers. I am suggesting to the witness if a doctor  
22 writes a generic description of a drug it may also  
23 be filled in some cases by one of several manufactu-  
24 rers' products. Is that not the case?

25 MR. DENHOLM: Mr. Chairman, that is  
26 certainly so. I believe the point is, and certainly  
27 the question is, as I understood it, was the  
28 percentage of drugs which are available on the market  
29 by generic name unbranded.  
30



1 MR. WHITELEY: Even some of the smaller  
2 manufacturers --

3 MR. DENHOLM: There is no brand name  
4 for them.

5 MR. WHITELEY: Even some of the smaller  
6 manufacturers do they not sell their products by brand?  
7

8 MR. DENHOLM: Size has nothing to do  
9 with it. Some large ones do, some small ones do.  
10 Some of the biggest manufacturers sell phenobarbital,  
11 this is the generic name, sir, without any brand name  
12 at all.

13 THE CHAIRMAN: I thought the point the  
14 question was intended to bring out was there are many  
15 kinds of drugs which are not available on the market  
16 under generic description only.

17 MR. HINKSON: Yes, Mr. Chairman. That  
18 is the point.

19 THE CHAIRMAN: And that they are  
20 available under trade name.

21 MR. HINKSON: Yes.

22 THE CHAIRMAN: Normally with a generic  
23 name also.

24 MR. HINKSON: Yes.

25 THE CHAIRMAN: But that there are a  
26 great many drugs you cannot get simply by generic  
27 description. When you buy them you will not find the  
28 label on the box or bottle contains only the generic  
29 description.  
30



1 MR. HINKSON: That is the point, Mr.  
2 Chairman.

3 THE CHAIRMAN: There is a trade name  
4 as well.

5 The only way in which many kinds of  
6 drugs are available, while they have generic descrip-  
7 tion, they also have a trade name of a particular  
8 manufacturer.

9 MR. HINKSON: That is correct.

10 THE CHAIRMAN: You cannot get it from  
11 any source that has not got a trade name attached to  
12 it?

13 MR. HINKSON: That is correct, sir.

14 Mr. Denholm, would you look at page  
15 12 of the Green Book, paragraph 27. There is a refe-  
16 rence there to an indication from the Registrar under  
17 Serial No. 298. Perhaps it would assist the Commis-  
18 sion because this extract refers to a document, if  
19 we had the witness explain just the circumstances  
20 under which this letter was written. Have you the  
21 reference there?

22 MR. DENHOLM: Yes I have, sir.

23 MR. HINKSON: Can you tell the Commis-  
24 sion how you came to or just what you were dealing  
25 with in the course of this matter. This was a  
26 communication in reply to a letter, was it not, from  
27 one of your members, Mr. Bamber?

28 MR. DENHOLM: Certainly. Mr. Chairman,  
29  
30



1 the reference referred to in paragraph 26 on page 12  
2 of the Green Book - I beg your pardon - paragraph  
3 27 - began from a letter written to me by Flying  
4 Officer Bamber. Frankly, sir, the reference in the  
5 Green Book is out of context and purports to imply  
6 an attitude on my part without in any way giving a  
7 reason for it.

8  
9 I believe that this letter and the  
10 letter to which it was written in reply should be  
11 viewed to place this matter in proper context.

12 MR. HINKSON: You have before you, I  
13 believe, a letter from Mr. Bamber dated January 13th -  
14 of what year?

15 MR. DENHOLM: 1960.

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b/dpw

1 MR. HINKSON: And a copy of the letter  
2 from yourself to Mr. Bamber of January 15th, 1960.

3 MR. DENHOLM: That is right.

4 MR. HINKSON: It is, I believe, from  
5 the second letter of January 15th, 1960 that the  
6 excerpts are taken as contained on page 12 of the  
7 Green Book; is that correct?

8 MR. DENHOLM: Yes, it is from the  
9 second letter, Mr. Chairman, that the excerpt is  
10 taken except it is not an excerpt. It is a para-  
11 phrase. I think perhaps it should read the letter  
12 from the files of the Pharmaceutical Association to  
13 the Province of British Columbia written by the  
14 Registrar clearly implies a distrust of the low-cost  
15 drugs and pharmaceuticals of "fringe manufacturers"  
16 whose products are not subject to continuous quality  
17 control measures and the quality of which cannot,  
18 therefore, in the opinion of the Registrar, "be  
19 guaranteed".  
20

21  
22 MR. HINKSON: Perhaps it would assist  
23 the Commission if first you read the relevant por-  
24 tions of the letter of January 15th.

25 THE CHAIRMAN: What is the serial  
26 number of that letter?

27 MR. DENHOLM: That letter - it is  
28 two pages, Serial No. 299 and 300. This letter was  
29 written to me on the 13th of January, received on  
30





ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

1 the 15th of January, by Flying Officer V.F. Bamber,  
2 a pharmacist and member of this Association. A  
3 pharmacist at the R.C.A.F. Station at Comox, B.C.

4 This letter says:

5 "It is becoming a matter of frightening  
6 concern to note the enormous increase in the number  
7 of cheap copies of drugs being purchased by Ottawa  
8 for use by members of the Armed Forces and their  
9 dependents.

10 It is our hope that the Pharmaceutical  
11 Associations can do something to stop the manufacture  
12 of drugs that could be potentially dangerous, either  
13 due to being therapeutically ineffective or physiolo-  
14 gically harmful, especially preparations such as  
15 Sulpha, Penicillin, Meproamate, Stilboestrol, Thy-  
16 roid, etc.

17 There follows a list of some of these  
18 drugs now on our shelves".

19 Mr. Chairman, there is a page and a  
20 quarter of lists of drugs I won't burden you by  
21 reading. The letter then goes on:

22 "There are other products being copies  
23 but not of primary concern due to their being inert  
24 or because no harm could result from their use, e.g.  
25 Glycerin.

26 As example of typical cheap copies are  
27 Bell-Craig's Phenylephrine, which is the same as Neo-  
28 Synephrine; Selenium Sulphide Suspension, copy of  
29  
30



1 Selsun; Hexachlorophene Soap Cake by Gilbert, copy  
2 of Gamophen; Syrup Piperazine by Nadeua, same as  
3 Antepar; Aluminum Hydroxide Gel - Bell-Craig, a poor  
4 substitute for Amphojel Tablets; Antispasmodic Tablet,  
5 identical formula to Donnatal Tablets; Nadeau's  
6 Mephenesin, copying Tolserol; Gilbert's Mepro, which  
7 is a very poor copy of Equanil; Bell-Craig's Pehonxy-  
8 methylpenicillin (Pen V) which may or may not be up  
9 to strength; and Elliott-Marion's Phenylbutazone,  
10 which is even the same colour and size as Butazolidin.  
11

12 It is realized that many drugs are  
13 manufactured under different trade names by various  
14 ETHICAL drug firms, but these examples (especially  
15 the sub-standard Bell-Craig products) are manufactured  
16 especially for use by the Armed Forces - they even  
17 print the Catalogue numbers on their labels - and are  
18 obviously not put up for general distribution to all  
19 drugstores. It is very doubtful whether one could  
20 purchase Bell-Craig's Selenium Suspension(?) in any  
21 store; (the question mark signifies that, in the  
22 writer's opinion, a product that requires tremendous  
23 shaking to dislodge is not a good suspension).  
24

25 It is our suggestion that the Pharma-  
26 ceutical Association contact the Canadian Pharmaceu-  
27 tical Association, who in turn should question the  
28 policy of drug purchasing by the Armed Forces Medical  
29 Service, in order to try and get them to purchase  
30 drugs which are recognized as fit for use. There is



no valid reason why Servicemen and their Dependents should have to use questionable products by 'base-ment' manufacturers".

I replied to that letter.

MR. HINKSON: I can tender that as an exhibit. I understand my friend has it.

MR. HUME: Could the list of drugs be read into the record. The witness read the letter but not the list. I so ought.

THE CHAIRMAN: We could ask it to be written into the record.

MR. DENHOLM: That was my hope.

<u>"CAT. NO."</u>	<u>NOMENCLATURE</u>	<u>MANUFACTURER</u>
1-231/1	Benzalkonium Chloride 12.8%	Bell-Craig
1-231/3	" Tinted Tincture	"
1-383	Hexocrema	"
1-429	Ear Drops, Antiseptic	Nadeau
1-436	Elixir Vitamin B Compound	Fine Chemicals of Canada
1-520	Fl. Ext. Cascara Sagrada	Anglo-Canadian
1-620	Hydrocortisone Acetate Pdr	Gilbert
1-707	Liquor Iodi Mitis	Laurentian
1-800	Milk of Magnesia	Ingram & Bell
1-805	Mist. Ammonium Chloride	Nadeau
1-948	Phenylephrine 0.25% Soln	Bell-Craig
1-949	" 1% Solution	"
1-1060	Selenium Sulphide Suspension	"
1-1082	Soap, Hexachlorophene 4 ox Cake	Gilbert
1-1083	Soap, Surg. Liq. with Hexach. G.H. Wood	



ANGUS, STONEHOUSE & CO. LTD  
TORONTO, ONTARIO

Denholm

1308

	<u>CAT. NO.</u>	<u>NOMENCLATURE</u>	<u>MANUFACTURER</u>
2	1-1220	Suppository, Haemorrhoidal	Fine Chemicals
3	1-1244	Syrup of Piperazine	of Canada
4	1-1364	Bacitracin Ointment	Nadeau
5	1-1404	Cortisone Ophth. Oint.	Bell-Craig
6	1-1419	Sulphacetamide Oint. 10%	"
7	1-1422/1	Vit. A & D Conc. Liquid	"
8	2-15	Ascorbic Acid Tablet, 25 mg	"
9	2-16	" " " 100 mg	Nadeau
10	2-17	Aluminum Hydroxide Gel Tablet	" , Cummings
11	2-18	Aminophylline Tablet, 1½ gr.	Bell-Craig
12	2-19	" Compound Tablet	Canada Pharmacal
13	2-20/1	Antispasmodic Tablet	Nadeau
14	2-45	Calcium Gluconate Tablet, 7½ gr	"
15	2-64/6	Chlorpromazine Tablet, 25 mg.	Bell-Craig
16	2-115	Ferrous Gluconate Tablet	Gilbert
17	2-120	" Sulphate	Nadeau
18	2-132	Mephenesin Tablet	"
19	2-133/1	Meprobamate Tablet, 400 mg.	"
20	2-135	Methamphetamine Tablet, 5 mg.	Intra; Gilbert
21	2-135/1	Methenamine Mandelate Tablet	Nadeau
22	2-142	Milk of Magnesia Tablet	Bell-Craig
23	2-155	Phenobarbital Tablet, ½ grm.	Ingram & Bell
24	2-156	" " ¼ gr.	Nadeau
25	2-161	Phenoxymethyl Penicillin Tabl.	"
26	2-161/1	Phenylbutazone Tablet, 100 mg.	Bell-Craig
27	2-165/1	Prednisolone Tablet, 5 mg.	Elliot-Marion
28	2-165/2	Prednisone Tablet, 5 mg.	Nadeau
29			"
30			



<u>CAT. NO.</u>	<u>NOMENCLATURE</u>	<u>MANUFACTURER</u>
2-207	Sodium Salicylate Tablet, 10 gr.	Bell-Craig
2-211	Sulphamethoxypyridazine Tab.	Bell-Craig
2-240	Stilboestrol Tablet, 0.5 mg.	Nadeau
2-241	" " 5.0 mg.	"
2-250	Thyroid Tablet, $\frac{1}{2}$ gr.	" , Octo
2-255	" " 1 gr.	"
2-256/2	Triple Sulphonamide Tablet	Bell-Craig
2-257	Tyrothricin with Benzoc. Loz;	"
2-260	Vegetable Laxative Tablet	Nadeau
2-551	Heparin Ampoule, 1000 IU/cc	Bell-Craig"

MR. HINKSON: You replied to that under date of January 15th, 1960 and it from that letter the excerpts are contained, purport to be contained on page 12 of the Green Book.

THE CHAIRMAN: That is Serial No. 298.

MR. DENHOLM: Serial 298.

"Thank you for your letter of January 13th relative to the purchase of inferior drugs and pharmaceuticals by departments of the federal government.

This whole problem revolves around the looseness of provisions of the Food and Drugs Act which does not enforce quality control procedures at the manufacturing level thereby making it possible for fringe manufacturers (or as you so aptly call them, basement manufacturers) to place on the market





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1310

1 low-cost drugs and pharmaceuticals whose quality  
2 cannot be guaranteed. We have been doing a good  
3 deal of public relations work on this point but time  
4 and again have had it thrown back to us that if drugs  
5 were of inferior quality, how is it that the Depart-  
6 ments of Veterans' Affairs and National Defence use  
7 them? We have been replying in general terms that  
8 price rather than quality appears to be the first  
9 criterion in drug purchases by departments of the  
10 federal government. Your letter is the first  
11 concrete piece of evidence we have received to substan-  
12 tiate this statement and I would dearly love to make  
13 wide use of it in our present campaign.

14  
15 We have, as you may know, been endea-  
16 vouring to exert pressure through the Canadian Pharma-  
17 ceutical Association on the federal government to  
18 correct this disgraceful situation but these efforts  
19 have come to nought. We will continue to proceed  
20 through that avenue but in the meantime feel that we  
21 have a responsibility in terms of public protection  
22 to also proceed independently in these efforts.  
23 Would you have any objection to our using the informa-  
24 tion and comments contained in your letter in this  
25 connection? In using the information initially we  
26 would not, of course, reveal its source but we might,  
27 in the long run, be called upon to do so to substan-  
28 tiate the case we are making. I am concerned about  
29 the possible embarrassment to yourself under such  
30





1 circumstances and would not care to proceed along  
2 this track without your sanction. We could, of  
3 course, refuse throughout to reveal our source of  
4 information and will do so if it is your wish, but  
5 this might, in the final analysis, weaken our case.  
6 I would appreciate your early advice".

7  
8 Mr. Chairman, it is on the basis of  
9 that letter that this implied disgust is accredited  
10 to me at page 12 of the Green Book. It seems to me  
11 that it is a case of half reporting things. Any  
12 disgust that may be exhibited in this letter which  
13 I wrote to Flying Officer Bamber was occasioned in  
14 large part by the information in his letter. Here  
15 is a pharmacist who is not engaged in retail practice.  
16 He is serving in the Armed Forces and is providing  
17 pharmacy services to that section of the general  
18 public who are in the forces and by no stretch of the  
19 imagination could he be considered to have any econo-  
20 mic interest or axe to grind in this matter and here  
21 he is expressing his professional concern about some  
22 of the products which in his view are sub-standard  
23 as marketed today.

24 MR. HINKSON: Did Flying Officer  
25 Bamber authorize you to reveal the letter, Mr. Den-  
26 holm, to use it?

27  
28 MR. DENHOLM: Yes, I have two pieces  
29 of correspondence from Flying Officer Bamber in  
30 that connection. He first declined after consulting



1 his superiors and he then subsequently authorized me  
2 to release this information stating notwithstanding  
3 his superiors' feeling in the matter he was so  
4 concerned with this as a matter of public interest  
5 as a pharmacist he wished me to make whatever use of  
6 the information was necessary.  
7

8 MR. HINKSON: I think the other docu-  
9 ments are also in the Director's possession, or  
10 copies of them are. I don't propose to refer to them  
11 at this time.

12 THE CHAIRMAN: Any documents that have  
13 a serial number are.

14 MR. DENHOLM: The others are.

15 MR. HINKSON: There is one other  
16 matter I would like to draw to your attention. It  
17 appears at page 99 of the Green Book, paragraph 192.  
18 There is reference to a letter of February 9th, 1960  
19 from the Registrar of the Pharmaceutical Economics  
20 Committee to the Registrar of the Professional Fees  
21 Committee. It had Serial No. 293. This refers to  
22 the Druggists' Bulletin Service, does it not, Mr.  
23 Denholm, this letter?  
24

25 MR. DENHOLM: Yes, it does.

26 MR. HINKSON: I wonder if you could  
27 tell the Commission what subject matter was under  
28 discussion at this time and in what way this letter  
29 has reference to it?  
30

MR. DENHOLM: Yes, the subject matter



1 under discussion at this time was the professional  
2 fee at that time being employed or used by the  
3 Druggists' Bulletin Service. It was the view of the  
4 Professional Fees Committee and the Pharmaceutical  
5 Economics Committee that the system which Druggists'  
6 Bulletin Service were using at that time to which  
7 Mr. MacLeod referred earlier contained in paragraph  
8 168 had the result of creating a different profes-  
9 sional fee on each prescription with quite broad  
10 variations anywhere from 25¢ to \$1.75 as the profes-  
11 sional fee. It was the feeling of the members of  
12 the Association, of these two Committees, that this  
13 was quite improper and with this in mind they  
14 proceeded to discuss the matter with the principals  
15 of Druggists' Bulletin Service.

17 MR. HINKSON: What was the impro-  
18 priety from the Committee's point of view?

19 MR. DENHOLM: The Committee's point  
20 of view was that the professional fee on many pres-  
21 criptions because of this system that was being  
22 used was too high and should be lowered.

23 MR. HINKSON: What connection, if  
24 any, have you had - that is the Pharmaceutical Asso-  
25 ciation of British Columbia with the Druggists'  
26 Bulletin Service?

27 MR. DENHOLM: None whatsoever. This  
28 is the only matter in connection with which we had  
29 any discussion with them at any time.  
30



1 MR. HINKSON: There is other corres-  
2 pondence in this series, Mr. Chairman, relating to  
3 this subject matter. I thought it might assist - I  
4 don't think it clearly appeared from the document in  
5 the Director's possession which was what was being  
6 discussed here and in that light I thought it might  
7 assist.  
8

9 THE CHAIRMAN: Is this document you  
10 have been referring to quoted in full in the state-  
11 ment? Is that the whole of the letter?

12 MR. HINKSON: Yes, it is.

13 THE CHAIRMAN: In that letter apparently  
14 there is no reference to professional fees. There is  
15 reference to prescription prices. By this you  
16 certainly wouldn't get the impression they were  
17 talking about professional fees. They are referring  
18 to a discrepancy in prescription prices.

19 MR. HINKSON: Could you assist the  
20 Commission on that?

21 MR. DENHOLM: I thought, sir, that  
22 the explanation I have just given is an answer to  
23 this, that the wording is completely improper and  
24 incorrect, that the subject matter under discussion  
25 between these two Committees and subsequently between  
26 the Professional Fees Committee and the Druggists'  
27 Bulletin Service had to do only with the professional  
28 fee that was the result of the system being used at  
29 that time by the Druggists' Bulletin Service.  
30



1 MR. HINKSON: It is these kind of  
2 things, Mr. Chairman, that causes me concern when  
3 my friend says he is going to produce these things  
4 in Ottawa.  
5

6 THE CHAIRMAN: I think this requires  
7 some explanation. There is no reference to profes-  
8 sional fees and there is too --

9 MR. HINKSON: Prescription prices.

10 THE CHAIRMAN: Prescription prices,  
11 and the principal cause, apparently, for the  
12 Committee's concern was the system presently being  
13 used on quoting prescription prices by the Druggists'  
14 Bulletin Service. No reference to professional fee  
15 at all. Reading that letter you wouldn't get any  
16 idea they were dealing with professional fees.  
17

18 MR. DENHOLM: That was the aspect  
19 that the Committees were concerned with, precisely  
20 as I have outlined, Mr. Chairman, yes.

21 MR. HINKSON: I think that those are  
22 all the questions I have.  
23  
24  
25  
26  
27  
28  
29  
30



/AG/dpw

1 THE CHAIRMAN: Have you something  
2 further, Mr. MacLeod, because we don't adhere  
3 strictly to the rules of legal procedure, but we  
4 do try to keep within shooting distance.  
5

6 MR. HINKSON: I have no objection to  
7 my friend asking something further. Mr. Henderson  
8 has handed me another document, Mr. Chairman. If I  
9 might just intervene. It is Serial 327, also in  
10 the Director's possession, and it perhaps touches a  
11 little more closely --

12 THE CHAIRMAN: Is it referred to in  
13 the Director's statement?

14 MR. HINKSON: It is not, but it is  
15 in connection with this reference at page 99, and,  
16 as I say, the Director has a copy of this in his  
17 possession under Serial No. 327. It is a letter  
18 dated December 2nd 1959 from the Chairman of the  
19 Professional Fees Committee to the Druggists' Bulletin  
20 Service, and perhaps to assist the Commission  
21 Mr. Denholm could read it.  
22

23 MR. DENHOLM: This, Mr. Chairman, is  
24 a letter from Mr. E.A. Ranger, Chairman of the  
25 Professional Fees Committee, to Mr. Bell of the  
26 Druggists' Bulletin Service Limited:

27 "The Professional Fees Committee of  
28 the Pharmaceutical Association of the Province of  
29 British Columbia has been holding discussions on  
30 the various methods of prescription pricing currently





1 used in British Columbia as they are affected by the  
2 levying of professional fees.

3  
4 The Committee feels that the present  
5 formula by which suggested prices are arrived at in  
6 the Druggists' Bulletin Service is unrealistic. It  
7 is the Committee's conviction that adjustments in  
8 prescription pricing schedules should be made by way  
9 of adjusting the professional fee rather than by the  
10 imposition of a sliding scale of percentage mark-up.  
11 The application of a 40% mark-up on a certain group  
12 of items and a 50% mark-up on certain others leads to  
13 an inconsistency in what is generally interpreted by  
14 public, physician and pharmacist as the professional  
15 fee. The basic price of a product is the list price  
16 and regardless of how the final prescription price is  
17 arrived at, the professional fee is universally consi-  
18 dered to be the difference between the list price and  
19 prescription price.  
20

21 The present formula used by your  
22 Service gives a variation in fee from 75¢ to \$1.95.  
23 This variation is not justifiable to the public or  
24 to the medical profession and justification is in no  
25 way eased by outlining the transparent conception of  
26 a variable mark-up. Such a conception suggests  
27 immediately that these prescription prices are  
28 arrived at on the basis of 'how much the traffic  
29 will bear'.  
30

The Committee requests that you meet



1 with them at their next meeting to discuss profes-  
2 sional fees as they apply to the Druggists' Bulletin  
3 Service. The next meeting will be at 8.00 p.m.,  
4 January 19th, 1960 at the Association office. I  
5 would appreciate your early advice by phone at WE  
6 9-1711".  
7

8 MR. HINKSON: I think that casts a  
9 somewhat different light on the matter, that when  
10 they refer to prescription prices they were primarily  
11 concerned with the professional fee aspect of the  
12 matter.  
13

14 MR. MACLEOD: Will you read again  
15 the first sentence of the second paragraph of  
16 Serial 298.

17 MR. DENHOLM: Serial 298, Mr. Chair-  
18 man, being the letter from myself to Flying Officer  
19 V.F. Bamber. "This whole problem revolves around  
20 the looseness of provisions of the Food and Drugs  
21 Act which does not enforce quality control proce-  
22 dures at the manufacturing level thereby making it  
23 possible for fringe manufacturers (or as you so aptly  
24 call them, basement manufacturers) to place on the  
25 market low-cost drugs and pharmaceuticals whose  
26 quality cannot be guaranteed".

27 MR. MACLEOD: Are you not saying  
28 there that the product of fringe manufacturers,  
29 which are not subject to quality control, that the  
30 quality of those drugs cannot be guaranteed?



1 MR. DENHOLM: That is correct.

2 MR. MACLEOD: Isn't that what the  
3 Director has said in paragraph 27?

4 MR. DENHOLM: Pretty well, sir,  
5 without reference to why the opinion was held sir.

6 MR. MACLEOD: Yes, but it correctly  
7 states the opinion that you expressed in that letter,  
8 does it not?  
9

10 MR. DENHOLM: It correctly states  
11 the opinion of one sentence of the letter, yes sir.

12 MR. MACLEOD: Well, isn't that  
13 complete in itself, that you did say that you dis-  
14 trusted the quality of fringe manufacturers, whose  
15 products were not subject to proper quality control?

16 MR. DENHOLM: That is correct.

17 MR. MACLEOD: And that is what the  
18 Director said?

19 MR. DENHOLM: That is correct.

20 MR. MACLEOD: I don't want to cover  
21 any ground that I have covered before, and you will  
22 stop me, I know, Mr. Chairman, if I do. In answer  
23 to the questions of my learned friend you suggested  
24 that these Committees that you spoke of were largely  
25 concerned with the professional fee?  
26

27 MR. DENHOLM: Yes.

28 MR. MACLEOD: Isn't it a fact that  
29 you, your Association, as part of the Canadian Phar-  
30 maceutical Association, have been working on a



1 uniform scale of prescription prices for the whole of  
2 Canada, working toward that end?

3 MR. DENHOLM: The Canadian Pharma-  
4 ceutical Association, a Committee of the Canadian  
5 Pharmaceutical Association, has been working on a  
6 suggested prescription price schedule for use in  
7 negotiations with governments, be they provincial or  
8 federal, relative to the supply of, for example, the  
9 social welfare prescriptions that I referred to here  
10 in British Columbia today.

11 MR. MACLEOD: Yes, and as is mentioned  
12 in the statement. Did I not obtain from your office  
13 copies of the prescription pricing practices followed  
14 in every province in Canada?

15 MR. DENHOLM: That is correct sir.  
16 These were sent to us automatically as a matter of  
17 information, just as we send a good deal of our  
18 material to the other provinces for information.

19 MR. MACLEOD: And were those in fact  
20 referred to any Committee of your Association?

21 MR. DENHOLM: When they came in they  
22 were referred to the Professional Fees Committee,  
23 to see if they had any application to professional  
24 fees generally.

25 MR. MACLEOD: Isn't it correct to say  
26 that the Canadian Pharmaceutical Association, of  
27 which your Association is a member, is moving towards  
28 the formulation of this uniform scale in contemplation  
29  
30



1 of a national health plan? Isn't the position that  
2 if a national health plan comes into effect the  
3 druggists want to present a common front?  
4

5 MR. DENHOLM: I would not be able to  
6 answer that question sir. I think the answer should  
7 be obtained from the Canadian Pharmaceutical Association.  
8 The proposed schedule for government negotiations  
9 to which you are referring is still in the  
10 formative stages. When it has been finalized, I  
11 presume it will be accompanied by some statement of  
12 policy on the part of the Canadian Association, and  
13 we will then be in a position of either associating  
14 ourselves or not associating ourselves with that  
15 statement. This point has not yet been reached.  
16

17 MR. HUME: This reference to Serial  
18 298 and paragraph 27, to which your counsel has drawn  
19 your attention, commenced with the proposition that  
20 there is a readier acceptance of drugs put out by  
21 the large as compared with the small manufacturer.

22 Now, this has nothing to do with  
23 control or ethics or a cellar, or what they are,  
24 which is big and small. Then the Director says, for  
25 example, and quotes your letter. Were you referring  
26 in your letter to a large or a small manufacturer,  
27 or were you referring to one who was, as you  
28 describe it, a fringe manufacturer, a sort of base-  
29 ment or garage type of thing? Has it got anything  
30 to do with Serial 298, as you wrote it?





1 MR. DENHOLM: May I consult Volume  
2 1 of the transcript before I answer that question?

3 MR. HUME: Paragraph 27 of the Green  
4 Book.

5  
6 MR. DENHOLM: I am sorry to delay  
7 Mr. Chairman. I have this marked, if I can just put  
8 my finger on it. Yes, Mr. Chairman, certainly the  
9 fact that the first sentence of paragraph 27 has  
10 reference to a comparison of large and small, and  
11 then goes on to the references to which we have been  
12 referring from the correspondence to my comments  
13 regarding fringe manufacturers, if you will. There  
14 is no connection whatsoever between the two. Our  
15 position was set out clearly in the brief. We held  
16 at page 16, in paragraph 1: "We hold no views as to  
17 whether small manufacturers are preferable to large,  
18 or as to whether drugs manufactured in Canada are  
19 preferable to those ordered from abroad. Our  
20 interest rather is now centred on what control proce-  
21 dures have been followed by the manufacturer during  
22 the course of production." I think the position of  
23 the Association precisely was stated by Dr. Morrell  
24 in his statement to you in Ottawa, and this is from  
25 Volume 1 of the transcript, at page 135, Dr. Morrell  
26 was asked: "So, Doctor, you would assume there might  
27 be good drugs sold under brand names and poor drugs?"  
28

29 "I am sure there are".

30 And the same may be equally true of





1 generic drugs: "I am sure there are". "It is not a  
2 significant division".

3 Dr. Morrell: "No. In my opinion the  
4 significant thing is the facilities, ability and  
5 attitude of the manufacturer that is important, not  
6 the brand name".

7 This is our position precisely sir.

8 THE CHAIRMAN: Because of the word  
9 fringe manufacturers do you know any large manufac-  
10 turers that you would call fringe manufacturers?

11 MR. DENHOLM: This is a highly rela-  
12 tive term sir.

13 THE CHAIRMAN: I know.

14 MR. DENHOLM: And I used it in this  
15 letter in direct connection with the other corres-  
16 pondence which was attached thereto, in direct  
17 connection to the letter which had been written to  
18 me by Flying Officer Bamber.

19 THE CHAIRMAN: Would you say that any  
20 of the large manufacturers that you know is a fringe  
21 manufacturer?

22 MR. DENHOLM: I don't think I could  
23 answer this question, because what is large and  
24 what is small --

25 THE CHAIRMAN: There are a number of  
26 large manufacturers, and you would know them?

27 MR. DENHOLM: Yes.

28 THE CHAIRMAN: Would any of those be  
29  
30



1 fringe manufacturers in your opinion?

2 MR. DENHOLM: I don't believe so sir.

3 THE CHAIRMAN: I am trying to get at  
4 what you mean by a fringe manufacturer. Is a fringe  
5 manufacturer then a small manufacturer whose products  
6 are not subject to continuous quality control?

7 MR. DENHOLM: This is it sir, quality  
8 control, the lack of quality control is the predomi-  
9 nant issue.

10 THE CHAIRMAN: Not because he is small,  
11 but because he has not got the quality control?

12 MR. DENHOLM: That is right.

13 MR. WHITELEY: The list of products  
14 which were contained in the letter you received from  
15 Flying Officer Bamber. How many of those were made  
16 in Canada?

17 MR. DENHOLM: Well, I really don't  
18 know that I can answer that question, but perhaps  
19 Mr. Hume could assist. Some of these companies  
20 might well be Canadian subsidiaries of American  
21 companies, who produce the drugs in the United States.  
22 I don't know.

23 MR. WHITELEY: You don't know the  
24 companies?

25 MR. DENHOLM: I know the companies by  
26 name, but I am not sufficiently familiar with them  
27 to know if they are subsidiaries of American compa-  
28 nies or straight Canadian companies.  
29  
30



1 MR. WHITELEY: What knowledge did you  
2 have of what quality control they exercised?

3 MR. DENHOLM: I have no specific know-  
4 ledge of what quality control they exercised.

5 MR. WHITELEY: Well, didn't you make  
6 some reference that they weren't subject to conti-  
7 nuous quality control?

8 MR. DENHOLM: These products that  
9 were mentioned specifically which I read out to you  
10 were in the opinion of our pharmacist, who wrote  
11 this letter, sub-standard.

12 MR. WHITELEY: No, I thought this was  
13 your comment about continuous quality control?

14 MR. DENHOLM: Yes.

15 MR. WHITELEY: Are not those your  
16 words?

17 MR. DENHOLM: In the reply to Flying  
18 Officer Bamber?

19 MR. WHITELEY: Yes.

20 MR. DENHOLM: Yes sir. I have stated  
21 to him that there are companies who do not undertake  
22 it, and I have said to him that this is the first  
23 indication we have had of who some of the specific  
24 companies might be, without expressing any opinion  
25 as to the specific companies.  
26  
27  
28  
29  
30



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1 MR. WHITELEY: What company did you have  
2 in mind that did not have continuous quality control?

3 MR. DENHOLM: I don't know that I can  
4 name the companies sir.

5 MR. WHITELEY: To whom did you have  
6 reference then?

7 MR. DENHOLM: All the companies that  
8 Dr. Morrell had referred to when he made the submis-  
9 sion to you in Ottawa.

10 MR. WHITELEY: This letter was written  
11 before that.

12 MR. DENHOLM: Pardon?

13 MR. WHITELEY: This letter was written  
14 prior to that.

15 MR. DENHOLM: That is correct but all  
16 these same companies he referred to that he had him-  
17 self stated publicly on many occasions do not exer-  
18 cise quality control. We knew the situation existed.  
19 We have not, as I have stated --

20 MR. WHITELEY: How many of these small  
21 manufacturers are there in Canada?

22 MR. DENHOLM: I don't know. I have no  
23 idea, sir.

24 MR. WHITELEY: Could some of these pro-  
25 ducts have come from companies in Europe that are  
26 quite large?

27 MR. DENHOLM: Well, Mr. Chairman --

28 MR. WHITELEY: It is your knowledge I  
29  
30



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1 am interested in, not Dr. Morrell's.

2 MR. DENHOLM: We are interested here,  
3 sir, in the position of the retail pharmacists in  
4 this and it doesn't really matter whether 5% or 50%  
5 or one-half of one percent or 6% of the drugs on  
6 the market in Canada are possibly sub-standard.

7 The position of the pharmacist is:  
8 how would he know whether he has the 5% in his hand  
9 that he is about to dispense or the 95%?

10 MR. WHITELEY: That is what I am trying  
11 to find out.

12 MR. DENHOLM: The question was asked  
13 this morning if we ever endeavour to draw up a list  
14 of gold-filled companies, as it were, and certainly  
15 we have not attempted to do that. We have said to  
16 the pharmacist at all times form their own judgment  
17 in this matter.

18 MR. WHITELEY: Yes, but you have formed  
19 a judgment that you are expressing in this letter.

20 MR. DENHOLM: Yes.

21 MR. WHITELEY: I am trying to find out  
22 on what you base that judgment.

23 MR. DENHOLM: I base that judgment, as  
24 I think all pharmacist and physicians do, on their  
25 knowledge of the integrity of the individual firm  
26 they happen to be considering at any time. If they  
27 have no knowledge of it, they must endeavour to find  
28 out.



1 MR. WHITELEY: In the case of these  
2 companies you don't know whether they manufacture in  
3 Canada or whether they do not manufacture in Canada?

4 MR. DENHOLM: Not specifically, sir,  
5 no.

6 MR. WHITELEY: On page 16 of your  
7 brief the paragraph commencing on that page --

8 MR. DENHOLM: Pardon?

9 MR. WHITELEY: In your brief at the top  
10 of page 16 --

11 MR. DENHOLM: Yes.

12 MR. WHITELEY: You refer to drugs impor-  
13 ted from abroad. Do you mean from any country outside  
14 of Canada?

15 MR. DENHOLM: Generally speaking, sir,  
16 we mean drugs manufactured in North America and this  
17 is abroad. This is a general term which is used.

18 MR. WHITELEY: You distinguish between  
19 foreign drugs or United States and foreign drugs  
20 from other countries.

21 MR. DENHOLM: That is one way of putting  
22 it, sir, yes.

23 MR. WHITELEY: That is the distinction  
24 you are making?

25 MR. DENHOLM: I believe this same dis-  
26 tinction has been made to you before, yes.

27 THE CHAIRMAN: You mean by that really  
28 you do not think of American-made drugs as foreign  
29  
30





1 drugs at all?

2 MR. DENHOLM: Not in this context, sir,  
3 no.  
4

5 MR. WHITELEY: On page 10 of your brief,  
6 in the paragraph at the top of the page, you state  
7 there as a matter of convenience pharmacists have  
8 found list prices to be a satisfactory guide in arri-  
9 ving at the final cost of the prescription to the  
10 patient. What do you mean by "satisfactory"?

11 MR. DENHOLM: A satisfactory guide?

12 MR. WHITELEY: Yes.

13 MR. DENHOLM: Precisely, sir, that is  
14 outlined earlier in the brief. It would be impossible  
15 for the pharmacist to gauge his cost or dispensing  
16 each individual prescription in terms of services  
17 and overhead and so on, so he has had to work out  
18 some averages with respect to the average amount of  
19 money, in effect, it is costing him to provide the  
20 services and having done that, he then must choose  
21 some criteria or criterion at least upon which to  
22 base his general pricing system.  
23

24 In general it would appear that the  
25 manufacturer's list price has proved to be satis-  
26 factory.

27 MR. WHITELEY: Satisfactory from what  
28 point of view?

29 MR. DENHOLM: From the point of view  
30 of convenience, as I said here, and from the point of



1 view of the general cost of operation of the pharmacy.

2 MR. WHITELEY: That is what I say: in  
3 what terms is he satisfied with it? Does it give him  
4 sufficient remuneration for the services?  
5

6 MR. DENHOLM: As it relates to the cost  
7 of providing services of the operation of the pharmacy,  
8 overhead and so on.

9 MR. WHITELEY: He is satisfied with the  
10 return he gets by using that system?

11 MR. DENHOLM: As a basis.

12 MR. WHITELEY: What do you mean "as a  
13 basis"?

14 MR. DENHOLM: As a basis for prescrip-  
15 tion, for computing the final cost of the prescrip-  
16 tion to the patient.

17 MR. WHITELEY: On some of the evidence  
18 the Commission has received, it has been found that  
19 drugstores doing a substantial volume of prescription  
20 business and overall business, seem to get substan-  
21 tially higher returns than those doing smaller busi-  
22 ness.  
23

24 THE CHAIRMAN: Doing a smaller percen-  
25 tage of business.

26 MR. WHITELEY: A smaller total business.

27 In that case, would the larger store be more  
28 satisfied with this guide than the smaller?

29 MR. DENHOLM: I don't think I can  
30 comment on that, sir. This would be a matter of



1 individual business. I couldn't comment on this.

2 certainly the relationship of the per-  
3 centages, to which you refer, are contained in the  
4 general surveys conducted by the Canadian Pharmaceu-  
5 tical Association which are already in the Commission's  
6 hands and which are mentioned several times, in fact,  
7 in the Green Book.  
8

9 MR. WHITELEY: In this discussion of  
10 the professional fee, was the objective ever taken  
11 that you were to separate each professional service  
12 from the other activity of the druggist?

13 MR. DENHOLM: You mean from the commer-  
14 cial operation - from the front store operation?

15 MR. WHITELEY: No, in dispensing drugs.

16 MR. DENHOLM: I am sorry. I don't  
17 follow your question.

18 MR. WHITELEY: As I understood the  
19 discussion you had this morning with Mr. MacLeod, at  
20 some point you were endeavouring to segregate the  
21 professional aspect of the druggist's activities  
22 and arrive at a fee for that service.  
23

24 MR. DENHOLM: Specifically, yes.  
25 This was under discussion but as also mentioned this  
26 morning on the advice of our solicitor, we were told  
27 that this would be contrary to the --

28 MR. WHITELEY: Yes, I understand that  
29 part of it. I was more interested in the original  
30 aim. It was your original aim that you were going



1 to sort out and take your drugs at cost and you  
2 would have a professional fee.

3  
4 MR. DENHOLM: This was in general  
5 terms the plan that drugs would be taken over at  
6 cost price and a fee would be of a sufficient size  
7 to cover all the factors of overhead, as well as  
8 professional services.

9 MR. WHITELEY: In other words, you would  
10 abandon the list price practice altogether?

11 MR. DENHOLM: Yes sir, that was the  
12 suggestion.

13 MR. WHITELEY: That is all.

14 THE CHAIRMAN: Thank you very much,  
15 Mr. Denholm.

16  
17 Is there anybody here this afternoon  
18 who wishes to make any representation to the Commis-  
19 sion? I am asking you because if not then this will  
20 terminate the hearings here.

21 We will conclude the hearings. I  
22 would like to say in closing the meeting this after-  
23 noon that we appreciate the Pharmaceutical Associa-  
24 tion and Mr. Denholm probably in particular for  
25 probably having done a very great deal of careful  
26 and thoughtful work in the preparation of the brief.  
27 I am sure the Commission will find some benefit  
28 from the efforts you have expended.

29 MR. DENHOLM: Thank you.

30 --- Whereupon the proceedings adjourned to 3rd August.



INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	--	Chairman
A.S. WHITELEY, M.A.		Member of the Commission
PIERRE CARIGNAN, Q.C.		Member of the Commission
F.N. MACLEOD		Combines Officer, representing the Director of Investigation and Research

Proceedings of hearings commencing at 10  
a.m., Thursday, August 3rd, 1961  
in the City of Victoria, in the Province  
of British Columbia.



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THE CHAIRMAN: Gentlemen, we are

meeting here for a session in Victoria of the Restrictive Trade Practices Commission conducting an inquiry into the manufacture, distribution and sale of drugs.

We have had no advance information that anybody or any organization definitely would be making representations to us. We have been advised by letter, which only caught up with me yesterday afternoon, that the Government would not be in a position to do so, that they felt they would not be able to contribute anything useful at this stage.

Is there anybody here representing any organization, or who wishes to speak personally?

MR. HINKSON: I appear for the Pharmaceutical Association, but we have made our submission to you in Vancouver, and have nothing further to add this morning.

THE CHAIRMAN: Mr. MacLeod, do you have any information?

MR. MACLEOD: I have no information sir. I do have a short letter from Dr. Arthur C. Walsh, M.D., which reached me at the Hotel Vancouver after the hearing in Vancouver had commenced.

Is it the desire of the Commission that I read this into the record or file it?

THE CHAIRMAN: It contains information





1 that you think would be relevant?

2 MR. MACLEOD: It contains a suggestion  
3 in connection with generic and brand names.

4 THE CHAIRMAN: I think that would be  
5 useful to have on the record.

6 MR. MACLEOD: This is on the letter-  
7 head of Dr. Arthur C. Walsh, M.D. and Douglas E.  
8 Bebb, M.D., and it is dated July 31st, 1961, and  
9 reads as follows:

10 "To the Royal Commission on Drug  
11 Prices: A short brief based on 15 years experience  
12 in the practice of medicine.

13 A. Despite all the publicity to  
14 the contrary, the prescribing of drugs by their  
15 generic name does not mean that the patient will  
16 get the most economical product. The druggist may  
17 have in stock only the most expensive brand or will  
18 be reluctant to use a cheaper brand when he is over-  
19 stocked with an expensive one.

20 B. A better system would be for the  
21 doctor to specify on the prescription whether or  
22 not the pharmacist might substitute brands to give  
23 the patient a better buy. The doctor could use the  
24 following abbreviations:

- 25 1. N.S. No substitutions - in  
26 cases where he feels it is impor-  
27 tant in the treatment to have a  
28 certain brand of drug.  
29  
30



1 2. S.D. Substitutions if desired -  
2 if he prescribes a brand name through  
3 habit or convenience but feels no  
4 harm will result if the patient and  
5 or the druggist wish to use another  
6 brand that is more economical. Often  
7 generic names are difficult to remem-  
8 ber - a practical problem for the  
9 doctor when there are some 370 new  
10 drugs coming out each year.

11 3. L.C. Lowest cost drug - the  
12 druggist is to give the patient the  
13 lowest cost drug. The doctor feels  
14 that this patient, for this condition,  
15 should have the lowest cost drug  
16 available.  
17

18 In the case of 1 or 2 the druggist  
19 should put the name of the drug firm on the label so  
20 the doctor may be aware of the source of the product  
21 at a later date if need be - if, for example: he  
22 wonders why the treatment was ineffective.

23 This system leaves the druggist some  
24 discretion in the choice of product - as to its  
25 price and quality it also can give the patient a  
26 little choice, and thereby introduces a greater  
27 element of competition. It should be arranged so  
28 that there are not a lot of unnecessary 'phone calls  
29 to the doctor over these substitutions.  
30



1 Yours respectfully, Arthur C. Walsh,  
2 M.D."

3 Signed Arthur C. Walsh, and there is  
4 a note which it is probably not necessary to read,  
5 saying that this was prepared in a hurry, and apolo-  
6 gizing for the typing.

7 That is all I have sir.

8 THE CHAIRMAN: Do you have any comments  
9 on the letter, Mr. MacLeod?

10 MR. MACLEOD: Not at this time, sir,  
11 I don't think.

12 THE CHAIRMAN: I wonder if counsel  
13 for the Pharmaceutical Association feels that any  
14 comments might be made on the suggestions contained  
15 in that letter. The suggestions were apparently  
16 that the doctor might use certain abbreviations on  
17 his prescriptions to indicate first of all that he  
18 felt in a particular case a particular drug was the  
19 one which should be provided for the patient, and  
20 that in the second class of case he might indicate  
21 that substitutions could be made if desired.

22 As I gathered, that the doctor's  
23 views were he felt there would be many cases in  
24 which a doctor would have no special, particular  
25 views about the efficacy of one particular drug  
26 rather than another, but that any one of several  
27 containing the same ingredients would be satisfac-  
28 tory, and in that case he would allow by that  
29  
30



1 abbreviation substitutions to be made.

2 In the third class of case, he would  
3 put no limits on what the druggist might do by way  
4 of supplying the drug, except it should be the  
5 cheapest which would comply with the prescription.

6 I wonder if the Pharmaceutical Asso-  
7 ciation would have any views as to how that might  
8 operate?

9 MR. HINKSON: I think, Mr. Chairman,  
10 that at the present time in practice to a certain  
11 extent a pharmacist follows this type of procedure.  
12 That is at the present time where the doctor speci-  
13 fies the drug, whether by brand name or by manufac-  
14 turer's name, the pharmacist ethically is not  
15 permitted to make any substitution.

16 THE CHAIRMAN: It is a legal position,  
17 not merely ethical.

18 MR. HINKSON: That is also legal, yes.  
19 The choice of prescribing is the physician's, and  
20 the pharmacist is bound to fill that particular drug.

21 Where the doctor does not specify,  
22 then at the present time the pharmacist has the  
23 choice of selecting the particular manufacturer's  
24 drug.

25 Now, as I understand it, the doctor  
26 would add a third category, that is the lowest-priced  
27 drug on the market in certain circumstances, and I  
28 think that the pharmacist's main concern would be  
29  
30



1 to know that, first where the legal liability would  
2 rest in that situation, whether it would rest with  
3 the physician or with the pharmacist, because if it  
4 rests in law with the pharmacist, then I think that  
5 he would desire, as Mr. Denholm pointed out the  
6 other day, to know that he was supplying a drug,  
7 even though it were the lowest cost drug, that was  
8 of known quality as well.  
9

10 I think perhaps Dr. Morrell's evidence  
11 before the Commission in Ottawa to the effect that  
12 amendments are being considered to the regulations  
13 under the Food and Drugs Act to require quality  
14 control on the manufacture of drugs imported and  
15 manufactured in Canada may have some bearing on this.

16 I don't think I can usefully add any-  
17 thing further without consulting with my clients.

18 THE CHAIRMAN: Are there any others  
19 who wish to make any representations at all to the  
20 Commission this morning? If not, this is a very  
21 short meeting. I think as nobody is here to make  
22 any representations, the meeting was called for 10  
23 o'clock. It is almost 10.15. I think we will come  
24 to the conclusion there are not any people who wish  
25 to make representations.  
26

27 MR. HINKSON: There is one piece of  
28 information requested from the Pharmaceutical Asso-  
29 ciation the other day, and I think that was the  
30 number of so-called professional pharmacies in the





1 Province of British Columbia.

2 THE CHAIRMAN: If you have that infor-  
3 mation it might save some trouble if we could have  
4 it at this time.

5 MR. HINKSON: I am instructed it is  
6 34.

7 THE CHAIRMAN: 34 in the whole of  
8 British Columbia?

9 MR. HINKSON: 34 out of a total  
10 number of 483 pharmacists in the Province.

11 THE CHAIRMAN: Are most of those in  
12 the Greater Vancouver area?

13 MR. HINKSON: 270 of the pharmacies  
14 are in the Greater Vancouver area, Mr. Chairman.  
15 Over half of the so-called professional pharmacies  
16 are in the Greater Vancouver area.

17 THE CHAIRMAN: We have had some  
18 information previously that professional pharmacies  
19 practically do not exist in a small community that  
20 has no clinic or anything of that sort, that you  
21 find them in the larger centres such as Vancouver,  
22 and that you will find them in close proximity to  
23 a medical arts building, or any building where  
24 there are a large number of doctors practising.  
25 Is that the situation in British Columbia?

26 MR. HINKSON: Yes, that is the case  
27 in British Columbia Mr. Chairman.

28 THE CHAIRMAN: If there are no further  
29  
30





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1 representations, gentlemen, the hearing will come  
2 to an end and we will adjourn at this time.

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4 --- Whereupon the proceedings adjourned.  
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